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ANNUAL MEETING—APRIL 27 - MAY 1, 1957—HADDON HALL, ATLANTIC CITY

THE JOURNAL

OF

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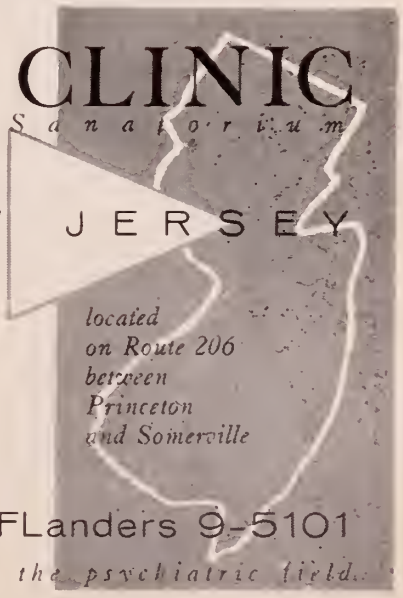
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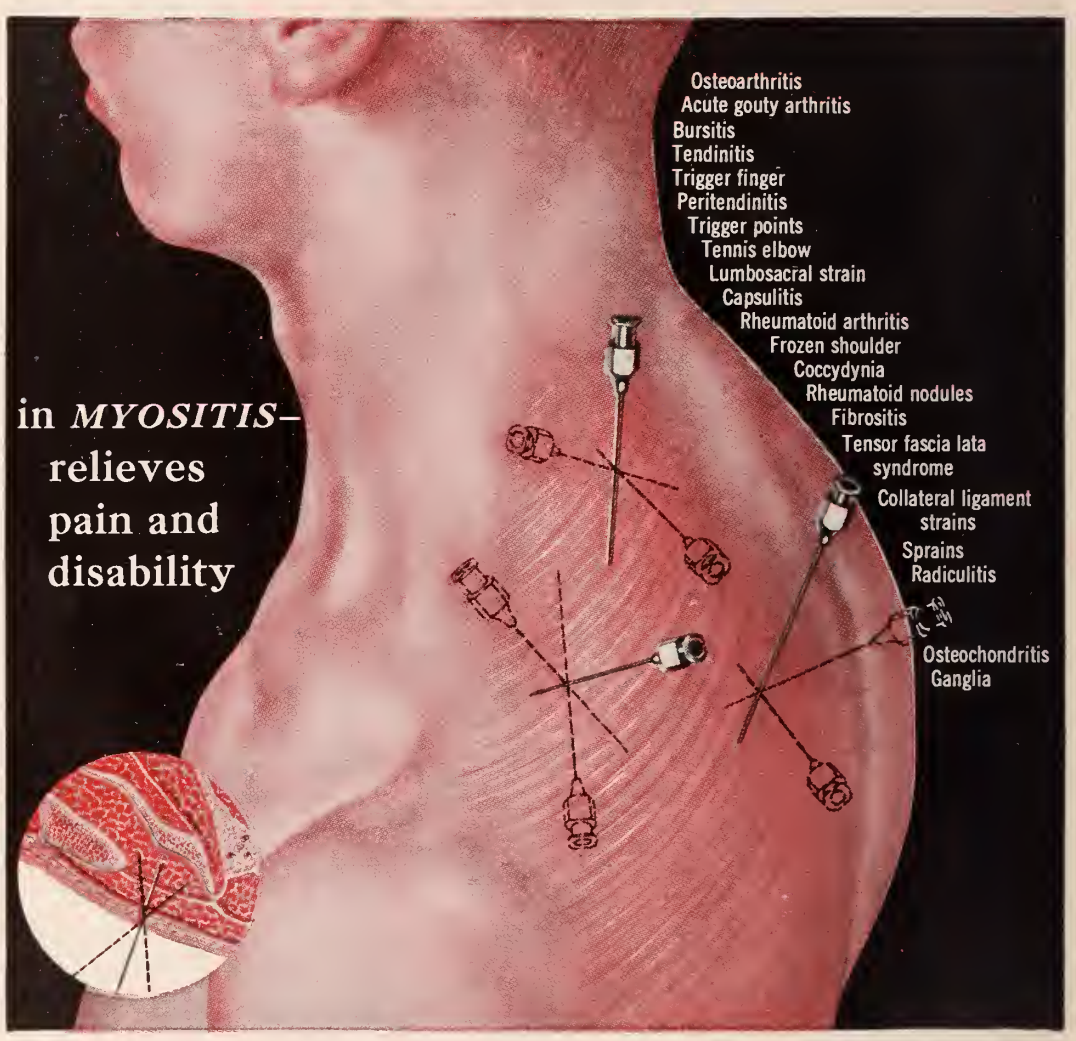
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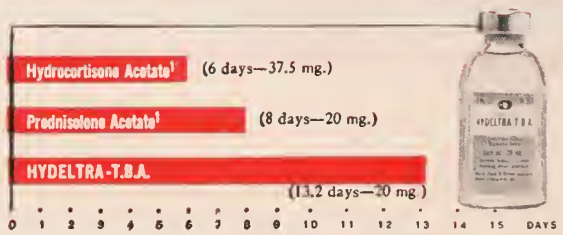
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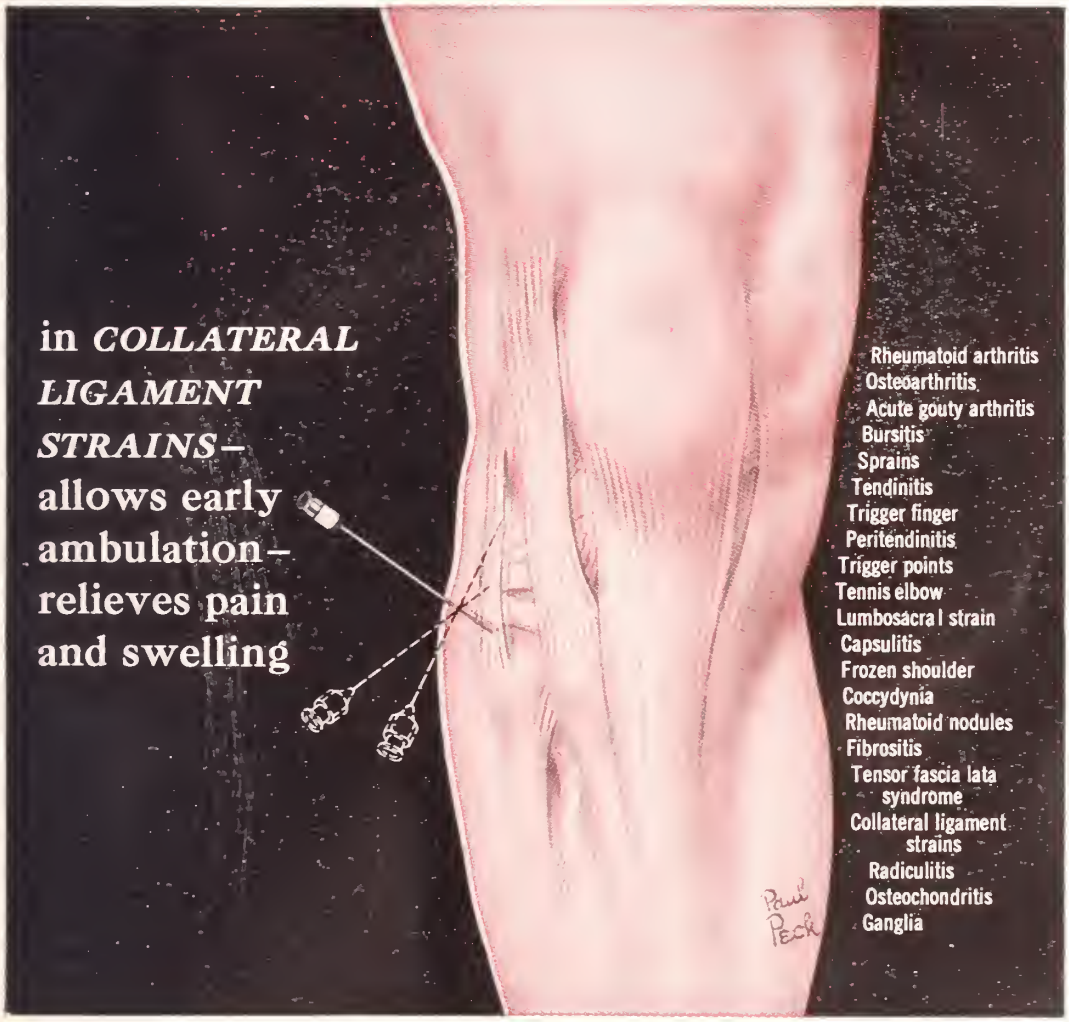
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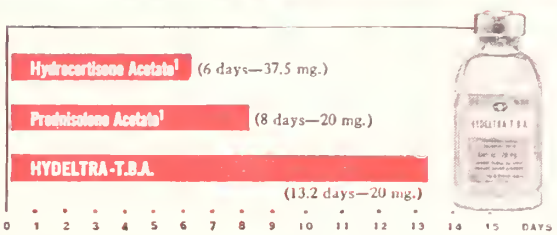
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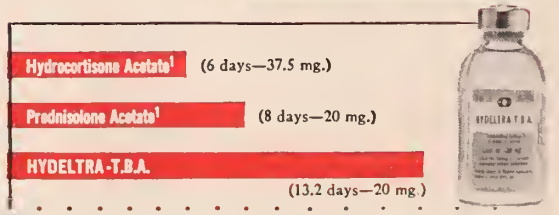
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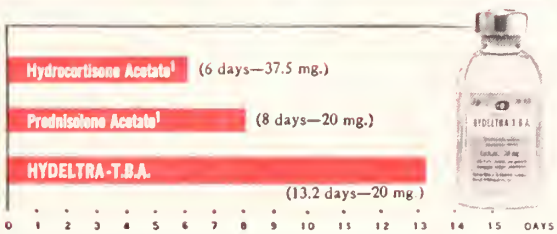
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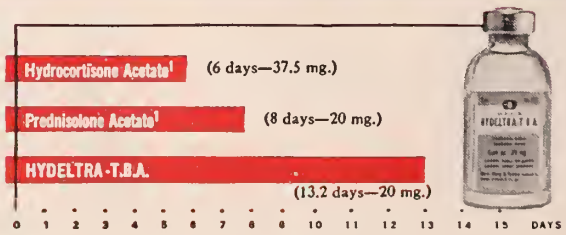
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Erythromycin in Treating Pneumonia

A 27-year-old man, a chronic alcoholic, was admitted with a history of an alcoholic spree followed by a cough, greenish sputum and chills and fever.

Physical examination showed a temperature of 104 F. and indicated pneumonia in the right lower lobe. This was confirmed by X-ray. The sputum revealed gram-positive diplococci and blood culture subsequently grew Type VII pneumococci.

The patient was treated with erythromycin, 300 mg. every six hours per os. His temperature dropped to normal by 48 hours and X-ray of the chest revealed considerable clearing by the fourth hospital day. After 10 days hospitalization, the patient was fit for discharge.[1]

First Antibiotics Symposium, we reported the successful treatment with thromycin of *H. influenzae* pneumonia and bacteremia. A second patient with *H. influenzae* pneumonia and bacteremia had a clinical course almost identical to the one previously reported, with cure obtained by treatment with 500 mg. of erythromycin per os every four hours for 14 days.

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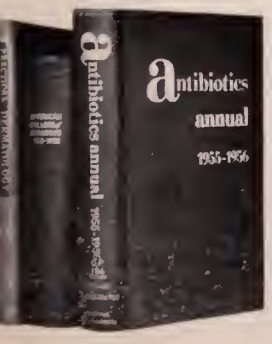
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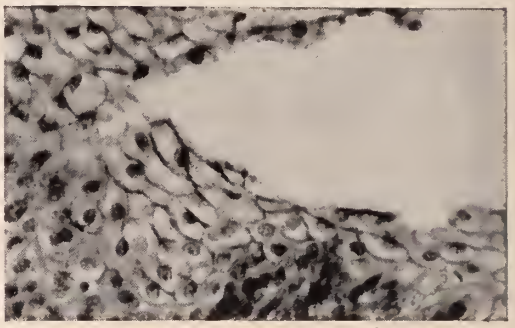
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HOW VAGISEC LIQUID

PENETRATES

RECESSES OF VAGINA AND EXPLODES TRICHOMONADS OFTEN MISSED

Photomicrograph of section of epithelium of normal vaginal mucosa, enlarged 750 times, shows uneven surface where trichomonads hide. VAGISEC penetrates surface and explodes organisms in hard-to-reach areas.



TOO OFTEN AN ORDINARY trichomonacide fails to cure vaginal trichomoniasis because it has little or no effect on parasites that are not on the surface.[1] Trichomonads burrowed deeply into the roughened mucosa survive and set up new foci of infection. In fact, even a few hidden trichomonads remaining after treatment can cause acute exacerbations. With VAGISEC® liquid and jelly you can overcome this most troublesome problem.

Penetrates thoroughly — This new and unique trichomonacide spreads out and wets the entire vaginal surface. It rapidly dissolves mucinous materials, fats and blood clots.[1] It penetrates the cellular debris that lines the vaginal walls and shields the parasites, reaching trichomonads deep in their hiding places.

Explodes trichomonads — VAGISEC liquid actually explodes trichomonads within 15 seconds after douche contact.[2] Two surface-acting agents and one chelating agent combine to weaken the cell membrane, to remove the waxes and lipids, and to denature the protein. With its cell wall destroyed, the parasite imbibes water, swells and explodes. All this occurs within 15 seconds. Only scattered fragments remain.

Proves highly effective — With the Davis technique† you can now rid patients of "trich," even cases that have resisted other treatment. VAGISEC liquid was developed as "Carlendacide," by Dr. Carl Henry Davis, M.D., noted gynecologist and author, and C. G. Grand, research physiologist.[1] Clinical trials by more than 150 physicians show better than 90 per cent success.[3]

Use liquid and jelly — In the Davis technique, VAGISEC liquid is used in office therapy. At the same time, liquid and jelly are prescribed for home use. They are well tolerated, leave no messy discharge or stain.

Office treatment — Expose vagina with speculum and wipe walls dry with cotton balls. Then wash thoroughly with a 1:100 dilution of VAGISEC liquid. Remove excess fluid with cotton balls. Dr. Davis recommends six treatments.

Home treatment—Patient douches with VAGISEC liquid every night or morning and then inserts VAGISEC jelly. Home treatment is continued through two menstrual periods, but omitted on office treatment days. Douching contraindicated in pregnancy.

One course of treatment—"If the treatment has been accomplished as directed," the patient "will have no flagellates provided the infection was limited to the vaginal canal . . . A few women have infected cervical, vestibular or urethral glands and require other types of treatment."[4] Continued douching with VAGISEC liquid two or three times each week for eight to twelve weeks helps prevent re-infection.

Prevents coital re-infection — Infected husbands are ". . . a potential source of re-infection in wives successfully treated."[5] Prescribe for your patients the protection afforded by Schmid high quality prophylactics. Specify the superior RAMSES® rubber prophylactic, transparent, tissue-thin, yet strong. If there is anxiety that rubber might dull sensation, prescribe XXXX (FOUREX)® prophylactic skins, of natural animal membrane, pre-moistened.

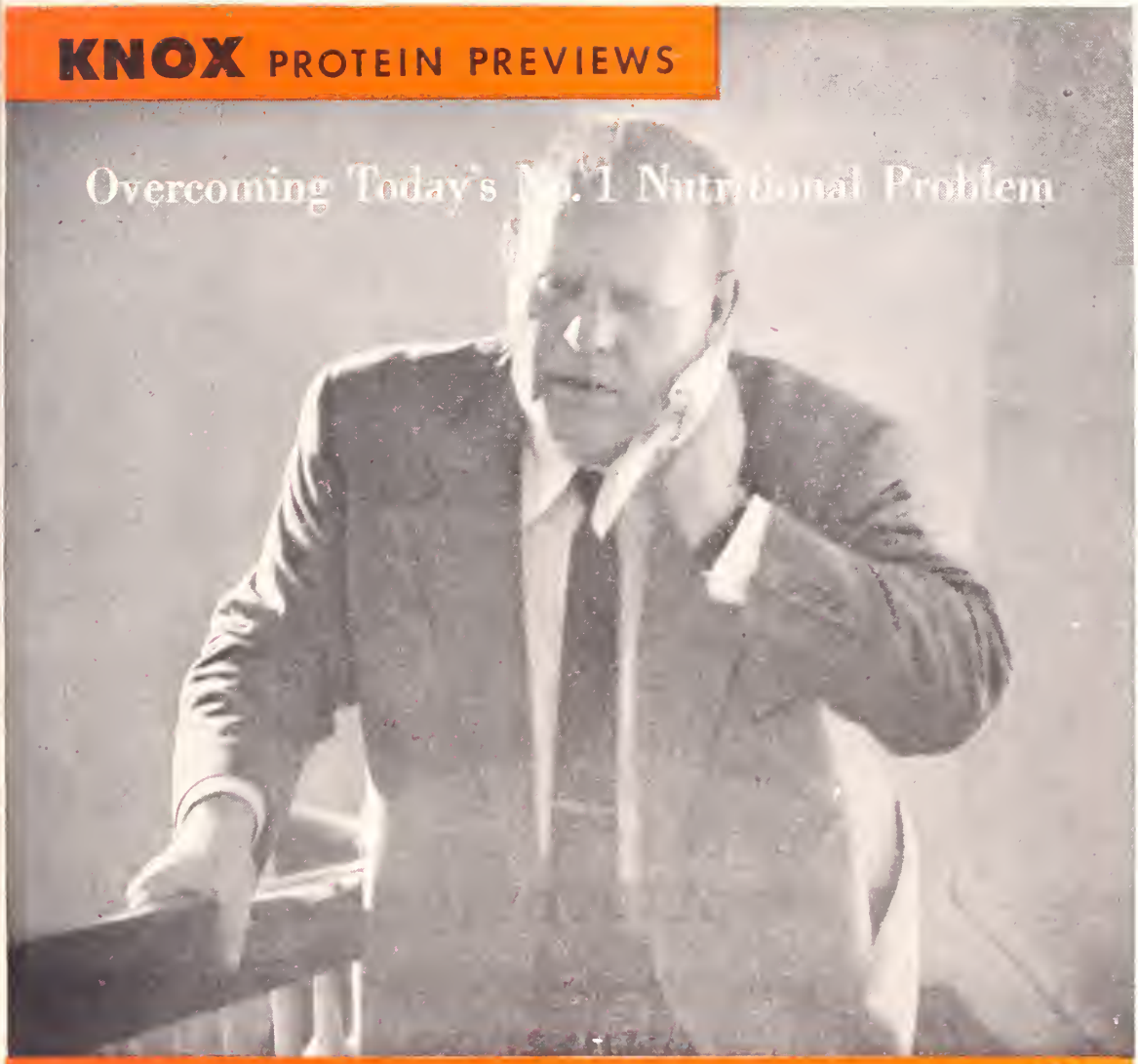
Active ingredients in VAGISEC liquid: Polyoxyethylene nonyl phenol, Sodium ethylene diamine tetra-acetate, Sodium dioctyl sulfosuccinate. In addition, VAGISEC jelly contains Boric acid, Alcohol 5% by weight.

References: 1. Davis, C. H., and Grand, C. G.: Am. J. Obst. & Gynec. 68:559 (Aug.) 1954. 2. Davis, C. H.: J.A.M.A. 157:126 (Jan. 8) 1955. 3. Davis, C. H.: West. J. Surg. 63:53 (Feb.) 1955. 4. Davis, C. H. (Ed.): Gynecology and Obstetrics (revision), Hagerstown, W. F. Prior, 1955, vol. 3, chap. 7, pp. 23-33. 5. Lanceley, F., and McEntegart, M. C.: Lancet 1:668 (Apr. 4) 1953.

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*Ferrer, F. P., and Boyd, L. J.: Am. J. Dig. Dis., 22:272, 1955
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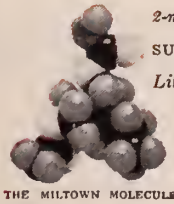
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eferences

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!. Freedman, L.: Angiology 6.52, Feb. 1955.
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4. J.A.M.A. 159:1208, 1955.
5. Stein, I.: Ann. Int. Med., Aug. 1956.

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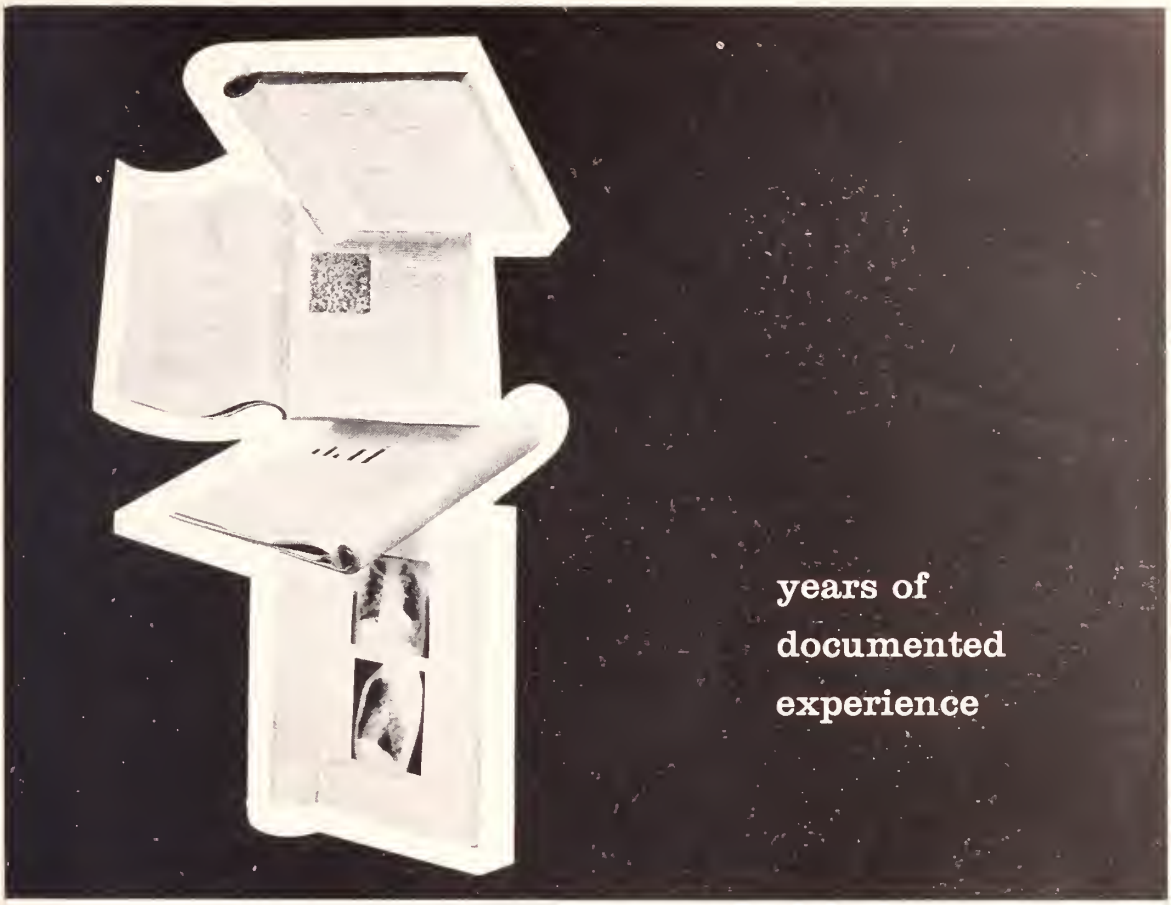
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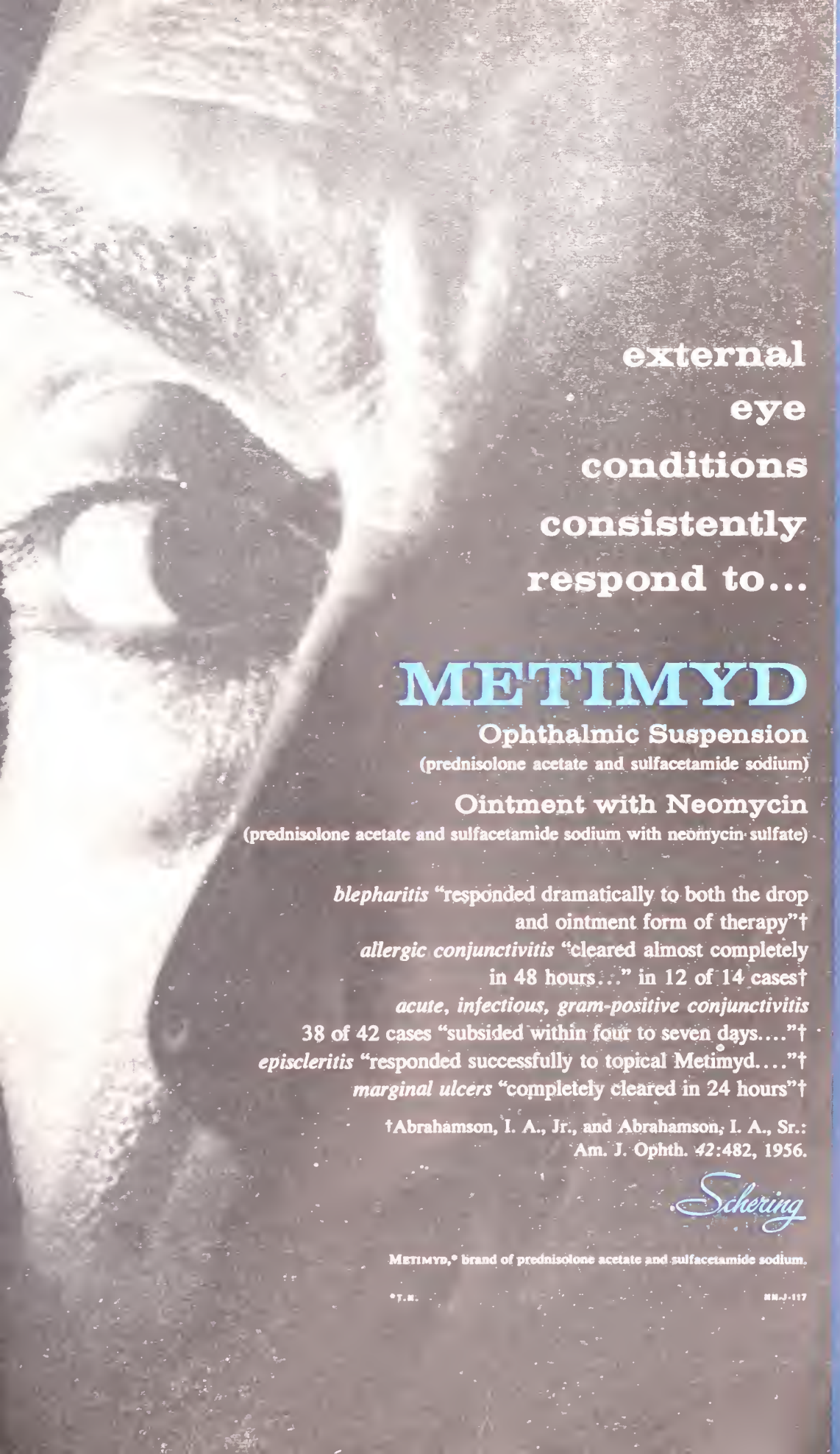
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Similar "supporting committees" have been organized in a number of other leading nations whose national medical societies, like the A.M.A., are members of W.M.A.

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Doctors and Organized Medicine

A recent AMA survey highlighted some interesting, but not always comfortable, findings. Only one half of the country's M.D.s are active in county and state organizations. One doctor in four failed to vote in his county society's last election. More than a third are more active in specialty groups not associated with AMA, than with the county or state society.

About half of the doctors think of county and state societies as being different from AMA. In reality, these organizations compose the national association.

About 90 per cent of doctors *in private practice* are AMA members. About 15 per cent say they belong because they think membership is necessary for hospital affiliation. Actually hospitals, not medical societies, determine hospital privileges.

Some members think that the AMA is not representative, criticize it for being "remote" and uninterested in the individual physician and complain about its "conservatism." About a fifth of the members say they do not get value received for their AMA dues.

When a physician criticizes AMA, he is criticizing his county and state society. When his society joins in the complaining, the breach within the ranks widens.

In the minds of some a mythical monster has been built up in AMA. Newspapers have contributed to this delusion. AMA *is* an influential organization and since it includes a majority of the nation's M.D.s, it *is* a spokesman for the profession. Over the years critics of organized medicine have driven in a psychologic rift by saying, "You individual M.D.s are O.K. and you're doing a good job—but AMA in Chicago is the villain!" In reality, the individual physician *is* AMA.

This insidious dissociation process may be a factor to the splintering off into smaller specialty groups which has become more widespread since the end of World War II. Unaffiliated organizations are less "controversial." They receive less attention in the press. Also many specialists feel that they can do something organizationally within the specialty society. Some members complain: "There's nothing to do in AMA."

The scientific programs of specialty groups appeal to many specialists. Difficulties develop when such organizations speak out on *nonscientific matters* affecting general medicine. The public then becomes confused and the impression is given that the members of the medical profession can't agree among themselves. Nobody denies the right of members to criticize their own organizations. But there are times when it is vital to present a united front. Those who believe in democracy accept the premise that the opinions of the majority should prevail — until the minority can change the opinions of that majority.

According to the survey, 50 per cent of the doctors attend most meetings of their county society. Yet 6 per cent attend no meetings; 16 per cent very few, and 9 per cent "some." The problem of meeting attendance is greatest here in the east, where only 38 per cent of the doctors attend "most meetings." Western states chalk up the greatest attendance; 61 per cent of the doctors turn out for meetings in the west. Central and southern states fall midway between.

Doctors in the east least often believe they get their money's worth in return for dues (23 per cent as against an average of 32 per cent). Physicians rate the American Dental Association higher in terms of favorable impressions than they do their own medical organizations. One doctor in twelve says he has

negative impressions of AMA while only one in 50 is critical of the dental association.

The individual physician proved to be more critical of his colleagues and of medical organizations than the public is. Many doctors say that most of the public looks upon AMA as a doctors "union" or as a "medical trust." Yet, a survey shows only 37 per of the public has this opinion. During the past few years, the medical profession has worked hard to regain the confidence and good will of the public. Now some concentrated *internal* public relations efforts are necessary to rekindle physicians' enthusiasm and interest in medical organizations. Larger numbers of physicians ought to be pulling their own weight in their societies, rather than dragging their heels and allowing a few men to do all the work. We ought to do a better job of informing our members about their activities, policies and services.

Physicians, in an effort to revamp their service programs for the public and to stave off a government medical program, have taken it on the chin from many critics. We have accepted just criticisms humbly and moved to correct sources of dissatisfaction. Now is the time to stop being on the defensive—to regain a sense of pride in our medical organizations. An organization sworn "to promote the science and art of medicine and the betterment of public health" need not apologize for its efforts to advance these objectives.

Always there is the cynic who says that the society is run by a self-appointed self-perpetuating clique. The best answer to this is the old, old saying of Tertullian: "You need to know the password to be admitted to the inside clique of organizational brass-hats. That password is a 4 word slogan. Whisper it in the president's or secretary's ear. The 4 words are 'I want to work.'"

Many like the prestige or office. But some are afraid of that little 4-letter word: W-O-R-K.

The Pharmacist as an Information Center

Sure, he sometimes tells a customer what to take for a cold. He shouldn't do it, and he won't admit doing it. He sometimes takes a foreign body out of the eye too—and let's face it, some pharmacists can do this beautifully. But for all that, he's far more our friend and neighbor, our ally and collaborator, than he is any competitor.

The magazine *American Druggist* made a survey of visits which physicians make to pharmacists. The number one reason was for personal needs—shaving tackle, cigars, antacid tablets and so on. Second commonest reason was for office supplies, and the third reason for information. The next three reasons, in order, were to drop in for a chat or social call, to pick up an item needed on a house call, and to leave a prescription for a patient.

The reason in the number 3 position, information on drugs, is intriguing. One would suppose that with every doctor's office haunted by detail men, and with such compendia available as *Physicians' Desk Reference*[1] and the *Modern Drug Encyclopedia*,[2] the physician would not be needing any more drug data. However, the pharmaceutical manufacturers are now pouring out products at such a tempo that a bound book on the subject is obsolete before the ink dries. And the detail man can hardly qualify as an impartial commentator on his competitor's products.

So the neighborhood pharmacist is, after all, a good depot for comparison shopping in new products. If the pharmacist would set aside a "new products section"[3] the physicians would appreciate it. Here, new products could be exhibited, and compared, and the literature filed. It would, of course, be unfortunate if this section were open to the general public in the front of the store. But if maintained as a purely professional station, it would add one more reason for the pleasant interlude of a physician's visit to his pharmacist-neighbor.

1. Published by Medical Economics, Inc., Oradell, N. J.

2. Published by Drug Publications, Inc., New York City.

3. This idea has been proposed by the editors of *American Druggist*. The editor of this New Jersey Medical JOURNAL cannot claim credit for it.

WILLIAM J. BROWNING, JR., M.D.

Merchantville

Management of Sleep Disturbances: Experience with a New Hypnotic Preparation

In prescribing barbiturates, the doctor is on the horns of a dilemma. The long-acting drug keeps the patient tossing in bed for hours and leaves him groggy in the morning. The short-acting barbiturate may cause him to awaken at 3 or 4 in the morning. Dr. Browning has tried encapsulated pellets of secobarbital which permit sustained release. These worked exceedingly well in 20 out of 28 patients.

PERHAPS the most common symptom reflecting the stress of everyday living is insomnia. The underlying causes of worry, overwork, repressed anger and depression invariably become worse and harder to manage once the exhaustion arising from sleeplessness sets in. Effective treatment must be directed against these underlying causes. The patient needs to be helped to recognize the cause-and-effect relationship between his emotions and his insomnia and, by a discussion of his environmental circumstances, to learn to cope with the problems arising from them. Sympathy, reassurance and tactful advice by the physician usually alleviate most psychogenic sleep disturbances, even though insoluble emotional problems exist.

To try treatment when the patient is haggard and desperately in need of sleep invites failure. A few nights of uninterrupted sleep often work wonders in restoring the insomniac, both physically and emotionally, and can be provided by giving an adequate dose of a suitable hypnotic. Once refreshed, the patient is inclined to be more receptive to counseling.

Recently a new preparation became available which, in a single oral dose, seems to provide a prompt soporific effect that lasts about eight hours. It consists of secobarbital prepared as micropellets and encapsulated. Some of the pellets are uncoated and release enough drug to produce a prompt onset of sleep. The remaining pellets, because they are coated with varying thicknesses of a digestible film, disintegrate gradually and sustain the initial therapeutic effect. This agent appears to overcome shortcomings in currently available hypnotics in several ways. While providing the prompt soporific effect of short-acting barbiturates, it spares the patient the inconvenience of taking middle-of-the-night doses. And although its effect is prolonged, the preparation—because it contains the rapidly metabolized secobarbital—is less likely to cause "hangover" than long-acting barbiturates. To determine whether this is so, the preparation was evaluated in 28 patients with chronic sleep disturbances.

MATERIAL AND METHOD

SIX men and 22 women, seen in private practice, ranged in age from 28 to 80 and averaged 55 years; many of the women patients were in the "menopausal syndrome" age group. All exhibited anxiety, tension and depression manifest as insomnia, their predominant presenting complaint. Almost all had previously taken hypnotics and could be considered reasonably good candidates to judge the effects of such preparations.

They were told to take one capsule of sustained release secobarbital* on retiring. Two dosage strengths were used, 1½ grains and 2¼ grains, depending on the patient's need. In general, the lower dose was given to those 60 years and over. Seven patients were started on 1½ grains and 21 on 2¼ grains; those initially given 1½ grains were later given the higher dose if the lower dose proved ineffective. They were asked to omit taking the capsules on the third night and, if possible, to use it thereafter only on alternate nights or not at all.

Patients were seen within a week after their initial visit and biweekly thereafter. A record was kept of the amount of drug taken by each patient and the nature of his sleep. The duration of treatment ranged from 3 to 78 weeks and averaged 25 weeks. Patients who used the drug for extended periods were instructed to take it only when necessary.

RESULTS

THE findings are concerned with the efficiency of secobarbital in a new pharmaceutical form rather than with the efficacy of the drug. Twenty of the 28 patients fell asleep within one-half hour after taking one capsule and slept uninterruptedly for six to eight hours. In four patients sleep, while successfully induced by the preparation, lasted less than six hours. The onset and duration of action varied in three patients. Two patients complained of feeling groggy or fatigued on awakening the following morning. When they changed from the 2¼ to the 1½ grain dose, one found the drug too weak for inducing sleep. Brief examples follow, illustrating typical responses.

A good response is exemplified by:

A 38-year old housewife and school teacher complained of nervousness, insomnia and frequent vague abdominal aches. A hysterectomy three years ago had brought on symptoms of "premature menopause." She felt so inadequate in handling her social life that she had withdrawn from most of her outside activities. Having lost 21 pounds, she appeared gaunt and tired. She was given 1½ grains of the encapsulated micropellets,* told to take one at bedtime and found that this enabled her to fall asleep quickly and to rest well throughout the night. In response to reassurance and routine menopausal therapy, she has gained weight and feels more relaxed. She notices none of the old aches and pains, has returned full time to her work as an elementary school teacher and in general finds her daily activities more interesting.

A fair response is seen in this case:

A 34-year old businessman developed stiff and painful joints in 1946. His disease had progressed gradually but out of proportion to his concern over his condition. He had become bitter about life and began brooding. Therapy with salicylates and steroids was no longer effective in relieving his pain. His brooding led to insomnia. This served to aggravate his distress. Steroids were temporarily discontinued, and a frank but tactful discussion of the relation of his mental outlook to his disease helped reconcile him. To relieve his insomnia he was given one 2¼ grain capsule of the micropellets* to take each night at bedtime. It provided restful sleep, ranging in duration from four to eight hours, depending on the presence or absence of severe discomfort. In subsequent consultations the patient, having resumed steroid and salicylate therapy, appeared confident. He gave the impression of being an arthritic who would not shrink into a shell of uselessness as long as his disease did not prevent him from carrying on his work.

A poor response is portrayed below:

A 53-year old housewife complained of "hot flashes," frequent headaches, nervousness and insomnia. She had labile, mild hypertension. Otherwise findings were within normal limits. However, she had become anxious and depressed and was extremely demanding at home. Previous treatment with sedatives had provided little relief, and counseling seemed to fall on deaf ears. Attempts to interest this woman in a hobby and in activities outside the home were also unsuccessful. At bedtime,

*Supplied for investigational use as 'Hyptrol' Spansule capsules by Smith, Kline and French Laboratories, Philadelphia, Pa.

guilt feelings set in and she invariably spent the night tossing restlessly and in the morning felt exhausted. Giving her one 2¼ grain capsule of secobarbital* at bedtime, even though it induced sound sleep, usually left her feeling groggy. Unfortunately, the 1½ grain capsule did not exert a strong enough action and the medication was discontinued.

This study is based on clinical impressions and is subject to the usual shortcomings of such investigations. Nevertheless, evaluation under these circumstances is not invalid, for physicians commonly prescribe and assess treatment on the basis of patients' comments. This study suggests that secobarbital in a sustained release capsule overcomes two common shortcomings of currently available hypnotics: the short-acting compounds that induce sleep promptly fail to provide an uninterrupted night's sleep; long-acting drugs usually take too long before inducing sleep and often leave the patient groggy in the morning.

Sympathy, kindness, reassurance and counsel are the keynotes in treating the underlying problems causing insomnia. Hypnotic drugs, by breaking the patient's pattern of sleeplessness, merely make him more receptive to treatment and better able to benefit from it. Since the tranquilizing drugs often relieve anxiety and tension, they may also provide beneficial adjuvant therapy. Some clinicians, however, advise against tranquilizers for mildly disturbed patients on the grounds that they mask symptoms and hinder treatment. This is something that the physician must decide for himself. Using drugs as sole therapy to provide symptomatic relief is a stop-gap measure. Treating the underlying emotional disturbances is the only definitive therapy.

SUMMARY

A NEW sustained-release preparation of secobarbital was given to 28 victims of insomnia. In dosage strengths of 1½ and 2¼ grains, one capsule was taken at bedtime for an average of 25 weeks. Twenty patients fell asleep after one-half hour and slept uninterruptedly for six to eight hours. In four cases sleep lasted less than six hours. Two patients complained of feeling groggy or slightly fatigued the following morning—the only side effects reported.

This new preparation overcomes two shortcomings of currently available hypnotics: short-acting compounds often fail to provide uninterrupted sleep, and long-acting drugs usually do not produce sleep immediately and often cause grogginess. Because it induces sleep promptly and maintains a uniform level of sleep throughout the night, this preparation should be useful in all cases of insomnia: that is, those patients who have difficulty falling asleep and those who are unable to stay asleep. By breaking the pattern of insomnia, this makes the patient more receptive to prolonged psychotherapy aimed at relieving the underlying causes: anxiety, tension and depression.

134 North Centre Street

Cortisone in Malnourished Children

Writing in *Pediatrics* (13:439, 1955), K. Glaser and E. Freundlich report that some malnourished children fail to gain weight or otherwise improve physically despite adequate dietary management. The authors assumed that in such cases, prolonged undernourishment and the stress of poverty-borne diseases bring about adrenal cortex exhaustion. Twenty-five unresponsive children were given 10 to 25 mg. cortisone daily for an average of 12 days. Response was considered good in 13 subjects. Cortisone is not a panacea but is of value in management of selected cases of severe malnutrition.

Peter J. Warter, M.D.

Trenton

Prednisolone-Hydroxyzine Combination* in Rheumatoid Arthritis

Uncomfortably high doses of prednisolone are sometimes needed in rheumatoid arthritis. Dr. Warter finds that by combining the steroid with hydroxyzine, he can reduce the dose of the prednisolone, thus making side-effects unlikely. As an added bonus, the combination has considerable tranquilizing value, too.

Among currently available agents, the glucocorticoids afford a great advance in rheumatoid arthritis therapy in selected patients. In the short time since Hench [1] reported the powerful effect of cortisone on this disease, several steroids have become extensively used. Their action, however, is only suppressive.[2] Their effectiveness derives from their action against inflammation in general rather than from specific actions against all aspects of rheumatoid arthritis. These compounds cannot, for this reason, supplant other therapy, but may be successful in selected patients and in conjunction with therapy directed toward other phases of the disease.

Prednisone and prednisolone have emerged as the most satisfactory of the newer glucocorticoids in treating rheumatoid arthritis: they often produce favorable effects in patients refractory to cortisone and hydrocortisone; they are effective in doses a fourth or a fifth that required with hydrocortisone. They have only a negligible effect on electrolyte balance.[3 to 9] The chief disadvantage of these compounds is the possibility of glucocorticoid side effects on continued use.[10] Among those more often observed are facial "mooning," disturbing changes of mood, and gastric distress occasionally followed by precipitation or aggravation of peptic ulcer. Recent reports [11] suggest that these phenomena are no more frequent with the meti-steroids than with hydrocortisone.

Since their adverse effects appear to vary with the dosage employed, steroids should be administered at the lowest possible daily dosage, and discontinued as early as possible. The optimal dosage is one that produces submaximal rather than maximal symptomatic benefit.

Any factor tending to reduce the amount of steroid necessary to accomplish a given effect deserves critical study. It might be possible to effect such a reduction by combining steroids with other agents. The intimate correlation between anxiety states and rheumatoid exacerbations suggests that an ataractic agent might potentiate the action of steroids, or provide effective therapy for the emotional components of rheumatoid arthritis. The role of psychogenic factors in this disease has been discussed in a previous publication,[12] in which it was emphasized that every arthritic expe-

*This preparation is trade-named Ataraxoid® (Pfizer). The material used in this study was kindly furnished by the Medical Department of Pfizer Laboratories, a division of Chas. Pfizer & Co., Inc., Brooklyn, N. Y.

riences several fears; a fear of crippling, of economic instability, of social deprivation, and of disinterest on the part of his family. Methods of minimizing these anxieties should assist in preventing exacerbations of rheumatoid disease.

Accordingly, a study was developed to test the idea that combined steroid-ataraxic therapy might be superior to therapy with steroids alone. It was decided to use prednisolone as the steroid component in the study, since a number of patients were available who were already taking this compound, and their response was accurately known. As the ataractic component, hydroxyzine was chosen. Hydroxyzine is a piperazine derivative with ataractic effects.[13] Its effects in anxiety-tension states are comparable to those of chlorpromazine and reserpine. In fact, many patients respond more satisfactorily to hydroxyzine.[14,15] In contrast to chlorpromazine and reserpine, hydroxyzine demonstrated an extremely low order of toxicity, suggesting that it would be suitable for extended periods of therapy.

MATERIALS AND METHODS

A TOTAL of 6 men and 15 women were available for study. All but one had received steroids previously for rheumatoid arthritis. Their response to steroid therapy was known. In each case the disease was marked by emotional factors likely to benefit from the added effects of hydroxyzine. All had shown signs of rheumatoid arthritis for 18 months to 20 years. Mean duration of the disease was seven years. During the 18 months prior to the study, all the patients had been under the care of the investigator. Most were receiving prednisone, prednisolone, or cortisone when the study began. Attempts had been made continually to restrict dosages to the minimum consistent with adequate maintenance.

All patients were started on a dosage of prednisolone equivalent to the amount of steroid they had formerly received: in most cases this was 15 or 20 milligrams of prednisolone daily, in divided doses. In addition, all patients received hydroxyzine in amounts equal to those of prednisolone. This was accomplished by the use of tablets combining 5 milligrams of prednisolone and the same quantity of hydroxyzine. During the next four months, an attempt was made to reduce the dose of the prednisolone-hydroxyzine combination.* At the end of the four-month observatory period the dose of hydroxyzine was increased to twice that of prednisolone, while that of prednisolone was unchanged. This was accomplished by the use of Ataraxoid® tablets combining 5 milligrams of prednisolone and 10 milligrams of hydroxyzine.* Again an attempt was made to reduce the dose of the prednisolone-hydroxyzine combination, and at the end of two months a final result was recorded for each patient.

RESULTS

OF THE 21 patients who completed the trial, it was possible in 12 to reduce the daily dosage of prednisolone when hydroxyzine was given concurrently. Two patients who had been receiving 15 milligrams of prednisolone were maintained on 5 milligrams when the steroid was supplemented by 10 milligrams of hydroxyzine. In eight others who had been receiving 10 to 15 milligrams of prednisolone, it was possible to reduce the steroid dosage by 5 or 7.5 milligrams. This reduction was possible in only three instances when the amount of hydroxyzine was equal to that of prednisolone, but was achieved in all 12 of the patients when the amount of hydroxyzine was increased to twice that of prednisolone.

In nine patients it was possible to reduce the prednisolone dose during the course of the study without increasing the symptoms of rheumatoid arthritis, but none of these patients required any increase in dosage.

Substantial clinical improvement was observed among most of the patients during this study, even among eight of those receiving reduced amounts of steroid. The table indicates the clinical status of the patients at the beginning of the study, and their evaluation after the period of therapy. Objective or subjective improvement of rheumatoid symptoms oc-

curred in ten cases. The most striking change was in the attitude of patients toward their disease and toward their affairs. This emotional improvement was observed in 14 of the 21 patients: it was reflected in more satisfactory acceptance of the management of their condition, and in the development of increased initiative and responsibility for their own improvement. In addition, anxiety was decreased and sleeping habits improved. The clinical status of the rest of the patients was maintained except in one patient, whose feeling of anxiety and "nervousness" was increased. The trial therapy was discontinued in this case, and the patient was maintained more satisfactorily on barbiturates.

STATUS ON ATARAXOID®

Patients	Previous Response Status	Steroid Dose	Clinical Response
1	Poor	R	Imp.
11	Fair	7-R	7-Imp.
		4-M	1-Worse
			3-N.C.
9	Good	4-R	6-Imp.
		5-M	3-N.C.

R: Dose reduced.
M. Dose maintained.
Imp: Clinically improved.
N.C.: No clinical change.
Three had not been treated with steroids prior to this study. In four patients in the "Imp." group, the improvement was subjective or emotional only.

In general the incidence and severity of adverse effects was lower on prednisolone-hydroxyzine* therapy than on steroid therapy alone. The facial "mooning" that sometimes accompanies steroid therapy was present to some degree in seven of these patients at the beginning of the study, and was relieved in two cases. Edema was present initially in two patients, but disappeared in one when it proved possible to reduce the steroid dose. A gain in weight noticed in two patients was halted, but there was no reduction in weight in either case.

Therapy was discontinued in two patients because of side effects. In both these cases moderately large doses of steroids were involved. One patient receiving 20 milligrams of prednisolone daily showed persistent peripheral edema, with no improvement of the arthritis; in the other, continued improvement on 15 milligrams of prednisolone a day was interrupted by a period of epigastric distress. Although there was no radiologic evidence of ulcer, continued distress necessitated withdrawing the therapy.

CONCLUSIONS

THE effect of prednisolone on rheumatoid arthritis is enhanced by hydroxyzine, in many instances permitting a substantial reduction in the dosage of steroid. Some of our patients even continued to improve after a reduction of 25 to 50 per cent.

This reduction of steroid dosage was accompanied by a general reduction in the severity of the side effects of steroid therapy. While several of our patients continued to display effects such as facial "mooning" that had been noted before the beginning of this study, these phenomena were usually diminished, and in certain cases disappeared completely. Therapy had to be discontinued in two patients because of serious side effects. This emphasizes the correlation of side effects and high dosage, since these patients were receiving 15 and 20 milligrams of prednisolone daily.

Combined therapy with prednisolone and hydroxyzine* generally yielded improvement in joint signs and symptoms. This was especially evident in the emotional status of patients: anxious patients were relieved by this therapy. While night sleeping was much improved, there was no instance of daytime drowsiness as is sometimes encountered using hydroxyzine alone.

Patients undergoing therapy with both steroids and hydroxyzine became in many instances much more amenable to management of their disease. During hydroxyzine therapy the opportunity was afforded for the first time in a number of cases to impress upon patients the emotional and physical adjustments that must be made for treatment to be effective and exacerbation to be avoided.

The greatest value in ataractic drugs such as hydroxyzine in rheumatoid arthritis may well lie in this aspect of treatment: that patients who have formerly rejected instructions

essential to simple recovery often become more approachable and more cooperative in their own behalf. The physician using this therapy is obliged to take this opportunity to persuade and educate his patients concerning their disease and its implications; otherwise the effect of the drugs may be no more valuable than simple sedation.

Ataraxoid® tablets containing 5 milligrams of prednisolone and 10 milligrams of hydroxyzine were used in this study.* Although it is possible to administer the two components separately, the prepared formulation offered several advantages. First, the ratio of the two components permitted adequate amounts of each to be administered in these patients; second, the ability to provide two compounds in a single preparation was more convenient both for the physician and patients; and third, the combination offered additional assurance that patients actually received what was prescribed.

SUMMARY

1. Ataraxoid* (a combination of prednisolone and hydroxyzine) was used in the management of rheumatoid arthritis in patients whose response to steroids was well-known.

2. Using this combination it was possible to reduce substantially the maintenance dosage of prednisolone in 12 of 21 patients without sacrificing therapeutic effect in any case and with continued improvement in most of the patients.

3. Clinical improvement, reduction of steroid dosage, or both, was achieved in 18 of the 21 patients, and steroid side effects were generally diminished in intensity.

4. Therapy produced a tranquilizing effect in most patients that was not accompanied by drowsiness. In addition it was possible in many cases for the first time to gain the active cooperation of patients in the management of their disease.

27 West State Street

A reference list of 15 citations appears in the author's reprints.

Dental Medicine Case History Service

Case histories are available from the broad field of dental medicine for the year 1956-57. These include original 35 mm. Kodachrome slides of the oral condition, pertinent laboratory findings, medical background, roentgenograms, photomicrographs, and diagnostic criteria. A loose leaf binder and matching slide box will be furnished to each participant.

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For further information write to Mrs. C. Novembri, 2240 Channing Way, Berkeley 4, California.

John H. Hodges, M.D.
Philadelphia

The Lower Nephron Syndrome*

The term "lower nephron nephrosis" should be supplanted with the term "acute tubular necrosis." Treatment includes an electrolyte-free, low-protein, high-fat and high-carbohydrate diet during the oliguric phase. The artificial kidney may be a life-saver in severe cases.

Lower nephron nephrosis is a form of acute renal failure caused by necrotizing and degenerative lesions of the tubules. Since its description[1] by Lucké (1946), it has been recognized[2] that any part of the tubule may be involved. For this reason "acute tubular necrosis" has gradually replaced the earlier designation "lower nephron nephrosis."

The renal corpuscle, made up of the glomerulus and its capsule, is usually ischemic but is spared any visible structural change. Alterations in the tubules are of two types. The first is the *nephrotoxic* in which there is epithelial necrosis with preservation of the basement membrane. This occurs principally in the proximal convoluted tubules and tends to involve all the nephrons to a similar degree. The second is *tubulorhexic* and involves destruction of both the epithelium and the basement membrane of the tubule with lesions scattered at random throughout the entire tubule.[3]

Frequency of occurrence of the type of pathologic lesion is determined by the cause (Table 1). The nephrotoxic is seen especially in acute tubular necrosis caused by poisons such as bichloride of mercury and carbon tetrachloride. Tubulorhexic is the lesion commonly accompanying intense ischemia, such as in severe trauma, hemorrhage or anoxia. Release of unidentified substances from hemolyzed blood or from crushed or ischemic parts of the body is probably contributory to the damage from ischemia.[4] Severe renal damage from either group of causes is likely to result in both nephrotoxic and tubulorhexic lesions occurring in the same kidney.

The interstitial tissue is edematous and is infiltrated with a variety of leukocytes. Grossly the kidneys are often pale and enlarged.

TABLE 1.

CAUSES OF ACUTE TUBULAR NECROSIS

Nephrotoxic	*Tubulorhexic*
Bichloride of mercury	Shock
Bismuth	Anoxia
Carbon tetrachloride	Hemorrhage
Diethylene glycol	Septic abortion
Chromates	Hemolytic transfusion
Roentgen contrast media	reaction
Phosphorus	Burns
Sulfonamides	Muscle trauma or anoxia

Severe damage from any of these causes will usually result in a combination of nephrotoxic and tubulorhexic lesions.

*Read by invitation at the 190th Annual Meeting of The Medical Society of New Jersey, in Atlantic City, May 16, 1956. Dr. Hodges is Assistant Professor of Medicine at the Jefferson Medical College in Philadelphia.

1. Lucké, B.: Military Surgeon 99:371 (1946)

2. Oliver, J., MacDonwell, M., and Tracy, A.: Journal of Clinical Investigation 30:1307 (1951)

3. Oliver, Jean: Ciba Foundation Symposium on The Kidney. Little Brown and Company, Boston, 1954.

4. Kolff, W. J.: Medical Clinics of North America 48:1041 (July, 1955)

Recovery in the glomeruli starts as soon as the blood flow returns.[3] Filtration will occur promptly in undamaged glomeruli if the interstitial pressure is not too great. The flow of fluid tends to wash the casts, cells and cellular debris out of the tubules. Diffusion out of the tubules into the surrounding tissue and vessels will occur freely until the basement membrane is restored. This may increase the interstitial pressure and temporarily impede circulation within the kidney. Tubule cell replacement may start within several days where the basement membrane is intact. However, these new cells are immature and may not reach normal function for weeks or even months. Granulation tissue may prevent the complete restoration of the continuity of the tubule, in instances where the basement membrane is destroyed, with resultant permanent impairment of the function of the nephron.

THE clinical course of acute tubular necrosis, may be divided into three phases. Shock, if present, is the first phase. It is usually combined with renal vasoconstriction to cause a great decrease in renal blood flow. The second phase (period of little or no urine production) blends in with the first phase and may be evident clinically within a few hours of the onset of the shock, hemorrhage, trauma, ingestion of chemicals or other inciting cause. Oliguria may last up to 10 or 15 days and recovery still occur. Mortality is high in those who develop anuria, and about 75 per cent of the deaths occur during this period.[5] The third or diuretic phase is arbitrarily delineated as the time when the urine volume reaches one liter in 24 hours.[4] Polyuria may occur and is associated with the restoration of glomerular filtration coupled with the early repair of the tubules by cells which are as yet functionally immature and unable to carry on normal reabsorption.

Clinical manifestations are summarized in Table 2. The decreased circulation in the kidneys and the collapse of the glomeruli retard filtration. Swollen tubule cells, cellular debris and casts block the tubules. A decrease in urine volume or actual anuria results. The lack of excretion of urea and other waste products leads to azotemia which is frequently accompanied by nausea and vomiting. There tends to be a rise in plasma potassium due to an increased catabolism of the tissue cells of the body. The increased electrolytes together with the loss of bicarbonate in the urine and the lack of secretion of anions often produce acidosis. Impaired excretion of water and salt may lead to edema, especially if there is a continued fluid intake or parenteral administration of fluids in excess of that lost through the skin and the lungs. Pulmonary edema may occur. This, combined with the deleterious effect of hyperpotassemia on the heart, may lead to cardiac failure. Anemia may be present from the inciting cause such as hemorrhage. The urine usually shows a fixed specific gravity at about 1.010 even in the phase of diuresis. It usually contains protein, red blood cells and casts in variable amounts. Renal function tests are impaired and may show improvement after three or four weeks. During the period of diuresis, serum potassium and sodium may either rise or fall below normal levels. Retention of phosphorus due to impaired excretion may cause phosphatemia, hypocalcemia and tetany. Hypertension, as in other renal diseases, is common. The weakened and disorganized condition of the body predisposes to infection.

TABLE 2. CLINICAL MANIFESTATIONS

Shock
Azotemia
Oliguria, rarely anuria
Electrolyte alterations:
(1) Hyperpotassemia or hypopotassemia
(2) Hypernatremia or hyponatremia
(3) Hypocalcemia
(4) Phosphatemia
(5) Acidosis
Hypertension
Edema
Cardiac failure
Anemia
Infection

5. Swann, Ray C. and Merrill, John P.: Medicine 32:215 (1953)

TREATMENT

TREATMENT of acute tubular necrosis has been detailed by Kolff.[4] Swann and Merrill[5] point out the importance of individualizing therapy. Shock due to hemorrhage should be corrected immediately by blood replacement. Other forms of shock may be treated with 6 per cent dextran in 5 per cent glucose in water or by norepinephrine solution. Transfusion accidents or other forms of acute intravascular hemolysis may be treated by the immediate administration of 100 milliliters of 25 per cent mannitol solution. This is beneficial only if given in the first few hours and may actually be harmful if renal shutdown has already occurred. Tzanck[8] has had success in the use of massive exsanguino-transfusions for the reduction of free hemoglobin in the the blood plasma especially when used early after large incompatible blood transfusions.

The most important factor in the consideration of the maintenance of fluid and electrolyte balance is the severe impairment of excretion of these substances from the body during the oliguric and early portion of the diuretic phase. The insensible loss of fluid from the body averages 700 milliliters per day and the total fluid allowed per twenty-four hours is the sum of 700 plus the urine volume and any other fluid lost from the body. This averages 1000 milliliters of fluid per day. Oral feeding is the preferable route. A naso-gastric tube may be used if necessary. Parenteral routes are to be avoided if possible. The fluid intake is increased in the diuretic phase, paralleling the increase in urine volume and averages 2½ liters a day.

PROPER electrolyte regulation requires frequent appraisal of the serum sodium and potassium. The most important factor in the prevention of electrolyte abnormalities is the administration of an electrolyte-free diet during the oliguric phase. Borst[6] drew attention to the increased catabolism of protein in uremia which tends to increase the blood urea and potassium, especially when the renal excretion of these substances is impaired. He advocated a diet low in protein and high in carbohydrate and fat. This has the effect of decreasing the endogenous metabolism of protein. Details of the diet have been reviewed and revised by Kolff.[4] Naso-gastric tube feeding is preferable to intravenous feeding if the patient is unable to eat. A popular formula consists of glucose 200 Grams, commercial fat emulsions such as Lipomul-oral® or Ediol® 200 Grams and water to make one liter. A liter of such an emulsion contains 1600 to 1800 calories. Bull[7] and his group, recognizing the tendency of the Borst diet to cause nausea, recommended the routine use of the naso-gastric tube for the daily administration of 400 Grams of glucose and 100 Grams of peanut oil (approximately 2500 calories) emulsified with acacia and given by continuous drip. When the patient is already in a state of serious uremia and electrolyte imbalance, it may be too late to start this regime. Then, the use of the artificial kidney should be considered. Mild hyponatremia in the oliguric phase is usually caused by a shift of sodium to an intracellular position, is not a true deficiency, and should be disregarded. Even a small amount of sodium must be administered with caution because of the ease with which it may cause pulmonary edema. Further restriction of water intake may improve an apparent hyponatremia. Extremely low sodium levels may be aided by sodium lactate or bicarbonate of soda. Potassium intoxication may present acute clinical symptoms with slow pulse, decreasing blood pressure, anxiety, restlessness, weakness and hyporeflexia. Temporary aid may be obtained by the administration of hypertonic glucose with insulin, 10 per cent calcium gluconate or hypertonic bicarbonate of soda given intravenously. Exchange resins have not proved practical in the control of either sodium or potassium excess. Dialysis with the artificial kidney may be effective where other measures fail. As diuresis occurs and the daily fluid intake is in-

6. Borst, J. G. G.: Lancet 1:824 (1948)

7. Bull, G. M.: Proceedings of the Royal Society of Medicine 45:848 (1952)

8. Tzanck, A. and others. "Traitment des Néphrites Aigues Anuriques; par les Methods D'epuration Extra Rénale," Masson et Cie, Editeurs. Paris, France (1952) Page 176.

creased, there may be a gradual addition of electrolyte-containing foods to the diet. Severe acidosis may indicate the use of sodium lactate which may be given orally in dilute aqueous solution. Accurate charts of fluid intake and output are a necessity for the proper direction of therapy.

Hypocalcemia and phosphatemia may be rapidly improved by the intravenous administration of 10 milliliters of 10 per cent calcium gluconate. Commercial combinations of aluminum hydroxide and magnesium trisilicate given orally may aid in reducing the level of serum phosphorus.

Acute pulmonary edema and heart failure are treated by the limitation of fluid intake and by digitalization. Venesection should be performed if immediate relief is imperative.

Vomiting may respond to the parenteral administration of chlorpromazine. Abdominal distention may be relieved by prostigmine.

Anemia is common in acute tubular necrosis. Swann and Merrill[5] have demonstrated that it tends to be progressive until it has reached a level of about 8 or 9 Grams of hemoglobin and then remains stationary. Packed red cells are probably the best means of replacing blood if the anemia becomes more severe.

Antibiotics are indicated in infection. Dosage used is altered by the knowledge that with impaired kidney function a high proportion of the intake may be retained in the body. Penicillin is probably the safest. The tetracyclines may be started at their usual doses but thereafter should not exceed a total of 3 Grams a week. Streptomycin should be used with great caution because of the possibility of toxic effects.

The following two cases illustrate, respectively, a mild and a severe form of acute tubular necrosis:

CASE ONE

A 44-year old metal polisher used carbon tetrachloride on two successive days following a weekend of high alcohol consumption. On the third day he developed nausea, vomiting, abdominal pain, dyspnea, ankle edema and headache. A chronic cough was aggravated and complicated by mild hemoptysis. He was admitted to Jefferson Hospital on the fifth day. Blood pressure was 180/98, temperature 99.8. He had slight facial and ankle edema. Rales were heard at the bases of both lungs. The heart was enlarged and the abdomen distended. There was tenderness over the liver and bilateral costo-vertebral angle tenderness. Urine was acid, had a specific gravity of 1.015, contained 2 plus protein and, on microscopic examination, was found loaded with erythrocytes. Blood urea nitrogen was 94; creatinine 18.8 and the chlorides† 459. The bromsulphalein test (2 mg./kilo) showed 14 per cent dye retention. Serum sodium was 120, potassium 4.4, and the plasma carbon dioxide was 23.3 milliequivalents per liter. Urine output increased from 900 on the day of admission to over 5,000 milliliters six days later, with a simultaneous loss of edema. Blood urea nitrogen and the temperature were normal after the twenty-second hospital day.

This patient made a good response to conservative therapy consisting of limitation of fluids and a low protein, low salt diet administered orally. Digitalis and penicillin were used as supportive therapy.

CASE TWO

A 22-year old woman induced abortion by inserting a catheter through the cervix. This was followed by bleeding, and, within several hours, by nausea, vomiting, fever, and chills. On the third day, she developed crampy abdominal pain and because of the persistence of symptoms, she was admitted to Jefferson Hospital. Temperature was 102, pulse 100, respiration 40 and blood pressure 95/60. She was dyspneic. Sclera and mucous membranes were icteric. There was diffuse abdominal tenderness and muscle guarding. Uterus was enlarged to about the size of an eight weeks' pregnancy and the products of conception were presenting at the os. Ankles were slightly edematous. On the day of admission, she voided a total of 125 milliliters of reddish black urine. The serum drawn for chemical analysis was also reddish black in color due to the presence of oxyhemoglobin and methemoglobin. Clostridium Welchi were grown from a cervical culture made at the time of admission. The hematocrit was 30 volumes per cent. Leukocyte count was 39,200. Serum bilirubin was 27 milligrams.

During the ensuing period until death on the 27th day, there were episodes of lethargy, hiccoughing, vomiting, epistaxis, hypocalcemic tetany and finally drop in blood pressure. Urine output varied between 50 and 800 milliliters per 24 hours. Sodium was reduced to 120 milliequivalents per liter, potassium reached 6.3, chlorides 72 and carbon

†As sodium chloride.

dioxide 19. Serum calcium was reduced to 7.6 mg., phosphorus elevated to 13.4. Serum bilirubin decreased as blood urea nitrogen steadily rose from 94 to 360 milligrams. Creatinine rose from 9.5 to 26 mg. Hematocrit reached a low of 16 volumes per cent.

The low protein, low electrolyte diet frequently had to be supplanted with intravenous fluids. Infection was successfully controlled with penicillin and Terramycin.® Intravenous glucose and insulin were used to combat hyperpotassemia and calcium gluconate improved the hypocalcemia. Washed red cell suspensions improved the low hematocrit. The progressive azotemia and acidosis with general electrolyte disorder were indications for the use of the artificial kidney and preparations were in progress at the time of the patient's death.

This is an example of the type of patient who may be given a chance of survival by the early use of the artificial kidney.

SUMMARY

THE term "lower nephron nephrosis" should be supplanted with the term "acute tubular necrosis." Nephrotoxic and tubulorhexic lesions occur from the effect on the renal tubules of chemical, bacterial and other toxic substances, or ischemia, or both. Acute renal failure ensues.

The important factors of treatment are careful limitation of fluid intake, the use of an electrolyte-free, low-protein, high-carbohydrate and high-fat diet during the oliguric phase, close surveillance 24 hours of the day, the early consideration of the use of the artificial kidney, and the use of symptomatic treatment modified to be compatible with the temporary impairment of renal function.

1025 Walnut Street

Elastic Suit for Hypotension

The pattern of grandpa's red flannels has been altered slightly and used to make a pressure suit for people with a serious type of low blood pressure. This tight-fitting suit, made of elastic cotton-rayon knit material, applies pressure over the lower half of the body and helps prevent a patient with orthostatic hypotension from fainting when he stands up. For some it allows a return to work or enables standing for longer periods on the job.

The garment is described in the May 1956 Journal of the American Medical Association by Herbert O. Sieker, M.D., John F. Burnum, M.D., John B. Hickam, M.D. and Kenneth E. Penrod, Ph.D., of Duke University.

Postural hypotension results from inability of peripheral arteries to constrict and maintain enough pressure to force the blood back to the heart. The condition may be associated with diabetes or may follow a sympathectomy. A person with the disorder is all right as long as he is lying down, but when he stands, there is a sudden drop in blood pressure and he becomes faint.

Treatment technics include the administration of salt or drugs, use of elastic stockings and abdominal binders, and immersion of the lower half of the body in water. The suit, which keeps a steady pressure on the body and the arteries, appears to be more effective and practical than any of the other mechanical methods.

Six patients wore individually tailored suits during their waking hours for peroids up to 24 months. Four patients found the suit so practical and comfortable that they were able to return to part-time work and to carry on daily activities involving longer periods of standing than they had previously been able to endure.

The long-legged and sleeveless suit has zippers in the front of the trunk and on the sides of the legs to aid in donning it. The material is porous, lightweight, and maintains its original elasticity after months of wearing and washing, the authors said.

They concluded that the suit was of "significant help" in rehabilitating patients with severe postural hypotension.

Richard E. Gordon, M.D.

Englewood

Emotional Disorders of Pregnancy and Child-Bearing

One pregnant woman in 400 will develop a puerperal psychosis, and five times that many will develop psychoneuroses or other emotional or personality disorders. Dr. Gordon here reviews the etiology, pathology, prevention and treatment of these tragic breakdowns. He suggests a preventive program though, of course, no statistics can be cited to demonstrate the workability of this.

Emotional disorders of pregnancy and the puerperium have variously been labelled the parapartum, postpartum, gestation, puerperal, lactation and pregnancy psychoses, depending upon the time of onset of acute psychotic symptoms. We prefer to group these together under the general heading of the "maternity psychoses" or better, the "maternity syndrome." The present report includes a study of the literature as well as personal observations of 17 typical and 35 related cases.

The nonpsychiatric physician who sees these patients while administering antenatal care can often recognize the early signs of this disorder. He may be able to prevent or alleviate much of the later psychotic developments if he understands the interrelated factors underlying most cases, both in his own office or by recommending psychiatric referral before the situation gets out of control. This paper is intended to help him by presenting some of the facts and theories as interpreted by the authors.[13,24,45]

The symptomatology is often revealing of the patient's basic emotional problems. Usually these patients are depressed. This depression appears at any time during pregnancy, but becomes severe rather suddenly usually in the fortnight after delivery. However "breakdown" may occur during pregnancy or even up to 90 days after delivery. Other important features are withdrawal, confusion, anxiety, fearfulness, exhaustion and sometimes delusions or hallucinations.

The mental content is characteristic. It involves the child, themselves, their husbands parents, homes, friends, and physicians, their duties and responsibilities, and their fears. Primarily the patient is concerned about her child. She expresses inadequacy about caring for it, feels she may have rejected or neglected it, may feel homicidal toward it, or even deny its existence. Typically, the mother is very disturbed about her behavior. She feels guilt-ridden. She refuses to eat, wants to die, speaks of suicide. She may feel she will be destroyed because of her sins and speak of being poisoned, condemned or accused by others.

She may deny that she is married or say her husband is dead, that she must now return to her parents. Sometimes she says she will be abandoned by, injured, or will injure her husband or parents.

The home is another problem area which

frequently appears in patients' symptoms. They speak of destructive fantasies about it, wander away, or are indifferent to their housewifely duties. Rarely they attempt actual violence to the home or furnishings. Most of them are preoccupied with their duties, are compulsive, ritualistic, or are given to religious doubts.

Occasionally, patients express anger, guilt, or violence towards friends, physicians and others upon whom they have wished to depend. Sexual delusions involving the physicians are rare. Most express fears of insanity most commonly, but occasionally of other illnesses.

Prodromata usually occur.[11,16,47,48] Confusion, depression or other symptoms come on gradually during pregnancy. Of course many expectant and new mothers express normal concern about their offspring and suffer moderate depressions. The physician might specially heed these doubts and fears if certain morbid features appear in the history. These are described below.

FAMILY HISTORY

From 15 to 25 per cent of the patients who develop psychotic disorders give a history of psychosis in the family.[11,13,24,42,45]

Many of the women in patients' families, particularly mothers and sisters, have developed emotional disorders with pregnancy including the psychoses[13] mentioned in the preceding paragraph. In addition there is a large incidence of serious complications and death after childbirth in patients' mothers and sisters.

PARITY

As a general rule multipara who break down have a worse family history of mental illness, more severe predisposing personality traits, a poorer marital adjustment, and have a worse prognosis than primipara. This apparent paradox is explained below.[13,24,33,45] Many of these women have suffered illness, toxemia, stillbirths and spontaneous abortions with earlier pregnancies. These apparently predispose a woman to a psychosis with later pregnancies.[13,24,45]

PERSONAL BACKGROUND

Although at one time some authorities believed older women were more prone to develop these "breakdowns," current studies suggest that age is not important.

Many patients have suffered mild, but not incapacitating depressions earlier in life. However, a large proportion (variously reported as between 12 and 25 per cent) have suffered a previous mental illness. This group probably contains mostly schizophrenics.[11,24,32,45]

There is considerable controversy as to the importance of social and economic factors. Can war, economic depression or other major calamities influence the incidence of these disorders? Certainly there seems to be no correlation with income level. Other sociologic trends toward greater independence of young couples, movement away from place of birth and family and friends, greater emphasis upon careers for women, de-emphasis on the importance and satisfaction of child-rearing, homemaking and the like may be more significant.

Physical and physiologic abnormalities may influence these disorders. Normal pregnancy makes demands of the mother, saps her energies, interferes with her daily activities. Normal childbirth is accompanied by blood loss, and followed by the need for tissue rebuilding and repair and restoration of endocrine balance. Lactation draws upon some of the mother's total available energy. Thus, the pregnant or parturient woman is fatigued easily. This process does not end soon after delivery. The new infant makes considerable demands upon the mother's time and energy. It requires frequent feedings, changes, cleanings, and interferes with her regular routine for household management, prevents pursuit of other interests and activities, and disturbs her sleep and rest at night.

Therefore if the mother has also suffered physical debilitation due to illness, she is fearful of recurrence as well as more readily exhausted when she tries to care for her child. Physical illness complicating pregnancy and

childbirth is strongly related to development of psychosis.

Some of the more frequently noted complicating physical disorders are threatened abortions, cesarean sections, difficult and painful deliveries, severe lacerations, or postpartum infection.[9,18,24,27,31,33,45] The sympathy and understanding of the obstetrician, nurses and attendants may influence the mother's reaction depending on their ability to inspire the confidence of the patient, reassure her that she does not need to do everything herself, give a feeling of security, and relieve doubts and fears.

Some[2,7,30] believe that depression, overactivity, and delusions may be related to excessive stimulation of the adrenal cortex. Pregnancy and childbirth may stimulate Selye's "Alarm Reaction."[28] Several authorities have shown that continued administration of cortisone can produce a psychotic state in susceptible subjects.[26]

Another group of physical disturbances associated with these and other psychoses are the somatic manifestations of emotional disturbances. Anxiety alone is distressing. It usually is associated with insomnia and other psychosomatic disturbances: palpitation, loss of appetite, gastro-intestinal disorders, faintness, muscle tension, pain and so forth. These physiologic abnormalities often generate additional worry. The patient fears she has heart disease, cancer or other disorders. Fears are wonderfully attention-drawing. Patients complain of difficulty concentrating and confusion. They are distracted by their worries. Ability to think is slowed down by their depression.

Chronic anxiety often stimulates endocrine overactivity. This may be related to the adrenal imbalance noted above. No doubt a circular process is operating.

PSYCHOSOCIAL FACTORS

Family Influences: The most important influence in the familial history of these patients is the attitude of the patient's mother to the maternal role.[45] Motherhood is a job, taught by example and identification of daughter with mother. Usually, patients who develop these disorders have been poorly prepared to enjoy and handle this role confidently. Thus these patients frequently come from broken homes, homes in which mother died before the patient reached adolescence, where mother worked since the child was of pre-school age, or in which the child was shipped about from relatives to foster homes.

PSYCHOSEXUAL HISTORY

Some have emphasized the importance of sexual maladjustment and frigidity in the development of emotional disorders of pregnancy and childbirth. Others find no relationship. Most recent reports recognize that sexual matters, the patient's psychosexual history and attitudes, her knowledge or ignorance, sexual traumata, as well as the husband's skill and technic, play some part in these disorders.[11,28,32,39,47]

Complete sexual gratification is a powerful satisfaction that will help the woman who is less prepared for a housewifely and maternal role to reorganize her interests, values, and skills for matrimonial and maternal responsibilities. Inadequate gratification will reduce this stimulus to learning. Equally important in the woman already emotionally disturbed, sexual activity often assumes an anxiety-producing influence for it is directly related to the dilemma in which she now finds herself. Thus sexual desire may stimulate anxiety and exacerbate the patient's distress.

Family and Friends: Mothers are in a state of reduced strength after childbirth and need persons upon whom to turn for assistance. They will have trouble if the family are disinterested, unable to assist, far away, or rejecting; or if the couple is new to the neighborhood and there are no interested friends to aid and advise. If funds are low and a baby nurse cannot be obtained for the first weeks and months after childbirth, an extra burden is placed upon an already tired mother. Moreover, since there is considerable social pressure for independence, and ability to care for oneself, there is an increasing tendency for young women to demand of themselves that they not rely upon parents and others.

The Husband: The American housewife

generally depends more for her sense of accomplishment and self respect upon her husband's love and appreciation than does her husband on his wife's affection. When she is more confined by young children, she has few contacts besides him, the family and their neighbors. He is in wider contact with outside sources of approval through his associations at work. Thus a wife makes the major adjustment in marriage.[12] This adjustment is suddenly forced upon her after the child arrives to cut her off from interests and activities outside the home and to demand the major part of her attention and care.

THE woman whose husband offers no assistance, is unappreciative, intolerant of her fatigue, is critical and demanding has a much harder adjustment to make to maternity. A husband must recognize his wife's limitations, be prepared to arrange for outside help around the time of delivery, and assist with the diapering, bathing, dressing, and feeding of the baby. If husband and wife enjoy marital relations, share simple pleasures, particularly things that do not require much effort, she is not so likely to suffer an emotional disorder with childbearing. If she was completely unprepared for her new job, her transitional period in which she learns is made more pleasant and easy for her.[27,45]

A cooperative, helping, loving husband is a strong factor against development of a disorder in child-bearing, and a great help to rapid recovery if one develops. An immature, jealous, demanding husband may be an important influence in bringing on a psychosis and a drawback to recovery.

Personality Factors: What is the importance of the premorbid personalities of these patients? Authorities do not agree. Much of the controversy stems from the fact that each is studying a different group of patients, from state hospitals, from private hospitals, or in private outpatient therapy. Patients in state hospitals will be from an economically poorer class; and there will be a greater proportion of schizophrenia with schizoid and paranoid premorbid personalities in this group.* The middle class patients in private treatment come from a group which is more inclined to affective disorders and in which the patient's personality will tend more to be compulsive or depressive.* The "puerperal psychosis" group generally comes from rigid, immature and inflexible, and somewhat perfectionistic people. They usually are motivated to have children, but are often poorly prepared for the work involved. Often those who are not basically schizoid have achieved a considerable degree of success in other interests, activities and work; but they had not previously been interested in children, do not understand or enjoy the pleasures of raising children, nor take pride in assisting the development and accomplishments of babies and youngsters. They are usually fearful of responsibilities and dread making mistakes.

Thus pregnancy brings on a sudden awakening to their deficiencies. They express these consciously. Since they feel duty-bound to be good mothers they are in a dilemma. They cannot quit as they would an unwanted and unpleasant job.

Moreover they must curtail their previous interests and satisfactions. This sacrifice entails greater personal strain. Their rigidity and inflexibility makes it difficult for them to work out a program of gradually learning the new role of motherhood while gaining some satisfaction from their previous pleasures. It is not hard to see how childbearing can place quite a strain upon women of this temperament.

Interplay: No single problem is primary. They all add weight to overloading the patient to the point of "breakdown." Mother's preparation for the maternal role is of paramount importance. An unprepared woman may be a victim of a psychosis. The danger is greater if she is rigid and inflexible. The emotional and practical support of her husband will diminish the strain. If there is no possibility of assistance from family and friends the odds build higher against her. If she tries to assume other burdens, particularly moving or taking an outside job, she makes it still harder for herself.

*However, some of the wealthiest families produce schizophrenics and some of the poorest produce manics.—Editor.

In addition, if there is a hereditary or constitutional "tendency" to psychosis, and if there is a history of trouble in the family with childbirth or in her own previous pregnancies, the odds in favor of psychosis mount. Much physical trouble during or after pregnancy and childbirth increases the possibilities, and a constitutional tendency to hormonal imbalance in pregnancy contributes to the load.

Parenthood, and not pregnancy itself, is essential to the development of these psychoses. This is demonstrated by studies of husbands of pregnant women. The prospect of assuming a paternal role has thrown men into psychoses similar to those observed in women. These men, too, are immature and unprepared for the demands of paternity.[3,15,22,44]

DIAGNOSIS

If you look at any modern psychiatric textbook, you will look in vain for "puerperal psychosis." The current (1952) nomenclatures† of both the American Medical Association and American Psychiatric Association make no space for a "puerperal psychosis." Terminologically, there is no such syndrome. Most modern writers believe that the emotional disorders of pregnancy and the puerperium run the whole gamut of psychoses, psychophysiologic disorders, personality disturbances and psychoneuroses. Yet, there is a common thread, and the symptoms may be grouped together as a "maternity syndrome."

The less severe psychoneuroses are cared for by the general practitioner and obstetrician. The psychiatrists see only the more severe cases, usually the frank psychoses. Of these about 75 per cent are uncomplicated psychotic depressions. The others show a schizophrenic component.[4] True psychopathic personalities are rarely seen except among women unreasonably seeking abortions.

Since many of the patients suffer an emotional "breakdown" only at this one time of their lives and respond readily to treatment, the pure affective disorders may not be typical cyclic psychoses. In certain respects the depressions of childbearing are "reactive" in nature. They are associated with giving up what was a more interesting life to the patient, for a more difficult and less enjoyable one. Are not these depressions similar to the involutional psychoses? There is the similarity of endocrine and physiologic aspects as well as the factor of loss of a "job" or role in both.[24] At the menopause, women surrender motherhood and its satisfactions and activities. Men at the "involution" period suffer depressions as they anticipate declining abilities and sterile inactivity or when they lose their jobs or retire. Life without a satisfying role, without interesting activities, without the respect of others and without self-respect is depressing indeed. Both men and women who develop depressions at "involution" cannot see clearly how they will adjust to the new role forced upon them by "retirement" from their previous "job." There is considerable similarity then with the problem in childbearing depressions of giving up a tried role for an unknown and frightening one.

A few authors have asked why some patients suffer a psychoneurotic reaction, others an affective psychosis, and others a schizophrenic breakdown. Excluding the schizophrenics who will "break down" with what appear to be minimal external stresses, there is some correlation among depressed patients between the quantity of load and severity of the breakdown.

INCIDENCE

Most authorities estimate that psychotic reactions occur in one of every four hundred pregnancies.[9,11,13,16,24,35] Less serious disorders occur more frequently, but figures are unavailable. These patients generally do not reach a hospital where statistics would be kept.

TREATMENT

There are certain advantages to hospitalization. It relieves the strain on the patient and her family and it reduces the danger of homicide or suicide. But the traumatic emotional

†American Medical Association: *Standard Nomenclature of Diseases.* Blakiston, Philadelphia 1952; and American Psychiatric Association. *Diagnostic Manual of Mental Disorders,* Washington, D. C., 1952.

impact of hospitalization upon the patient and the lessened opportunity for learning her new job away from the home setting are countervailing disadvantages. Most authorities now recommend treatment at home, for the nonschizophrenic. They hold hospitalization in abeyance unless it becomes evident that the patient's disorder or her home situation is out of control.

Electroconvulsive Therapy is recommended for the patient who is inaccessible to psychotherapy, is too disturbed or is a potential danger.[11,24,45] This alone does not provide a permanent cure but it makes many patients amenable to psychologic and social reorganization.

Hormonal Therapy is recommended by some. Insulin coma therapy is used with schizophrenics, sometimes in conjunction with other hormones and electric convulsive therapies.

Tranquilizers have diminished the need for hospital care and shock treatment. Combinations of long acting chlorpromazine and rauwolfia derivatives, and quick acting meprobamate have been most successful. The former give the patient a calming baseline. The latter control tension. Insomnia is an important problem in this disorder, and many authorities recommend Carbamate® at bedtime. Doses may be repeated if the patient wakens. These tranquilizers are adjuncts to definitive treatment by diminishing tension and anxiety.

ABORTION AND STERILIZATION

THERE is much disagreement as to the necessity for these steps. Because of the serious religious, moral, legal and ethical implications, this aspect of treatment needs special attention and study. The usual arguments *for* therapeutic abortion, emphasize the dangers of suicide or homicide to the infant or family, or of a deteriorating psychosis developing.

Arguments *against* this so-final procedure are also presented. Foremost is the medical directive to save life, not to take it. This is given strength when we realize that most of these patients are now responding to psychiatric treatment. Moreover, psychiatry cannot yet predict which schizophrenic will deteriorate. Suicidal and homicidal patients can be hospitalized. Unwanted children, even of patients who are pregnant in mental institutions or who are unwed, can often be placed in childless homes. Particularly with Roman Catholic patients, there may be emotionally harmful effects, equal to, if not greater than, any beneficial results hoped to be achieved by this drastic procedure. Guilt at taking a life may increase the conflict in true cases of this disorder.

A most careful analysis of the pros and cons is essential before any decision is rendered. This study should be made by disinterested consultants.

Decision for sterilization is not to be taken lightly. Patients may have one psychotic episode in pregnancy, then adjust to the maternal role and have no more trouble with subsequent pregnancies. We have all seen the tragic cases of sterilized women, who later want and are ready for a child, and can no longer bear one.

PSYCHOTHERAPY AND SOCIAL THERAPY

MOST authors recommend psychotherapy, but there has been only a little comment upon the need for social therapy. In psychotherapy the first effort is to give the patient understanding of the forces that have overburdened her. These include her own personality, her conscientiousness and rigidity, her inexperience with the difficult role of motherhood and her lack of real pleasure from it, and her need to be independent which deprived her of help; the social factors which have aided or weighted her—the attitude and assistance of her husband, her family, her friends, economics and the like; the physiologic influences, the reasons for her inability to concentrate, or sleep, the nature of the psychosomatic symptoms she experiences. Some patients whose home situations were favorable, and to whom help was available if requested, begin to improve after the first treatment session; understanding the real nature of the difficulty is quite reasurring for it relieves her confusion and anxiety for her sanity, and sets her immediately to looking for solutions.

Social therapy is recommended immediately. Discussions with the family help them understand the problem. They are encouraged to assist patiently while the mother learns her new tasks. Oftentimes practical nurses and baby nurses are essential. Husbands and wives are encouraged to "socialize," especially with neighboring couples. Husbands are instructed in the difficulties and importance of parenthood and shown how to give assistance and appreciation to their wives. Sexual instruction is provided for both husbands and wives.

Psychotherapy is continued to help patients learn to curtail temporarily other careers and ambitions, recognize their limited values, and learn the new maternal pleasures and goals. This does not represent a giving up of ambitions, but development of a new career alongside of the one they already had. They are encouraged to make friends with other mothers for reciprocal aid as well as social contact. Finally, patients learn to face their fears of responsibility. After understanding their morbid origins they can discard the unrealistic aspects and learn to guard against the realistic dangers by planning and foresight, and the developing of effective skills.

PROGNOSIS

Schizophrenic patients do poorly. Patients who never learn to adjust to the maternal role but break down after having several children are generally in this category. Many factors gravitate against schizophrenics doing well. Their lives have been a long series of failures culminating in this last.* Their anxiety is greater. Usually their present social situations are not favorable. Yet many patients who develop out and out schizophrenic reactions respond well, especially if their breakdowns have been acute and associated with very apparent external stresses, rather than a slow withdrawing.[9,11,24,25,28,31,32]

On the other hand the neurotic and psychotic depressions have generally done well in time under a variety of treatment regimens. Probably the most important feature is that these women, regardless of the actual treatment administered, are learning to adjust to the role of maternity. Their breakdowns necessitate that husbands, families and friends lend assistance, alleviate the immediate burdens, and make it easier for mother to learn and return to her role.

The important personality, historical and physical variables in estimating prognosis have been described previously. Nonschizophrenic patients in whom personal and social matters are relatively favorable generally do well quickly. Those in which the personal history is dismal, and the social situation reveals no sources of help do less well regardless of treatment. Those unfortunates with a large schizoid component may retire to mental institutions for long periods. They are defeated before they start,* and the task of rehabilitation is enormous.

PREVENTION

The current hypothesis is that the primary problem is one of adaptation to a new and difficult role by individuals who are fearful, rigid and inflexible. Social factors which aid and assist or interfere and prevent learning are very important. If all this is true, it would follow that something might be done to prevent the development of these disorders in susceptible individuals.

A young woman generally begins to learn her sense of values early in life, in her parental home, and in her relations with her parents. However, attitudes and skills may be altered by later experiences, especially if anxiety has not made her too compulsive and rigid. She may be helped by antepartum preparation classes for husbands and wives. These should stress not only the physical aspects but also the emotional satisfactions of parenthood, the problems in reorganizing one's home life with children, cooperation with each other, and with family and friends, and the ultimate problems of getting overloaded. Often the woman who is in most danger of ultimate breakdowns does not seek this type of help, but pursues her own interests or career to the bitter end; and then the psychosis is upon her. She needs help *before* the child is born and *before* the stress of car-

*It really isn't that dreary—Editor.

ing for it. Attitudes are altered and skills assimilated more easily beforehand than after the psychosis has developed. Intellectual preparation for maternity will not help those already seriously disturbed. Basic training in maternal pleasures, responsibilities and skills, may help many borderline patients who were poorly prepared in previous personal life to learn to manage the difficult period of adjustment ahead of them.

If such programs are not readily available, obstetricians and general practitioners might themselves attempt to assist those who might be predisposed. The physician can caution such patients against assuming additional burdens at this time of their lives. He can point out to wife, husband and family the realistic difficulties and adjustment required, thus the need for greater assistance and cooperation with mother. Frequently he can recommend a baby nurse to assist and advise her. By his own tactful, patient, and sympathetic understanding and advice he can help the mother gain a better respect for her new role and learn to adjust to it slowly. He can encourage her to "socialize" more with the neighbors, take part in community mutual aid pograms which will help her build a respected place among other mothers, thus enhancing her own self-esteem. And he can assist those patients with sexual difficulties to achieve a better relationship with their husbands.

275 Grand Avenue

A bibliographic list of 50 citations appears in the author's reprints.

Facts About Drowning

The first nation-wide study of drownings has just been completed by a doctoral candidate at New York University's Center for Safety Education.

According to B. W. Gabrielsen, associate professor of education at the University of Georgia (author of the thesis) the most likely places for death on the water are lakes, rivers, and ponds. But such accidents happen in some unusual places. These include bathtubs, wells, cattle watering troughs, sewers, rain barrels, and even slop buckets.

The study underscores the importance of swimming at places where adequate life guard supervision is maintained. Only 2.2 per cent of the drownings took place at beaches or pools where life guards were in attendance.

Professor Gabrielsen also uncovered "the alarming fact" that *17 per cent of the drownings occurred among children under five who were left unattended by parents for a few moments.* The professor found that a large number of water death victims were of pre-high school age. To date, he noted, educators have concentrated on giving swimming instruction to persons of high school age.

The months with the highest incidence of deaths are June, July, and August. The day and the hour that appear most frequently on the accident records are Sunday and 4 p.m. More than 9 per cent of the victims had been under the influence of alcohol.

The ratio was six men for every woman victim. A quarter of the fatalities occurred after boats carrying non-swimming passengers had been upset. Only 26 per cent of the drownings happened to people who were engaged in recreational swimming.

The victims in the cases studied by Professor Gabrielsen were engaged in 27 different activities at the time of their mishaps. These included fishing, boating, ice skating, horseback riding, hunting golf balls, water skiing, and canoeing.

Carl P. Guzzo, M.D.

Orange

Congenital Disorders of the Pancreas

Dr. Guzzo's essay on the pancreas won the 1955 *award of the New Jersey Anatomic and Pathologic Society. This article is part of that essay.*

Aberrant pancreatic tissue having no connection with the main gland may occur anywhere along the gastrointestinal tract. It is more common near the pyloric end of the stomach and duodenum. In 41 per cent of cases that have been reported from the Mayo Clinic, 27 per cent were duodenal, 25 per cent were gastric, 15 per cent in jejunum, and 5 per cent in Meckel's diverticulum.

The importance of this disorder depends on the location, the size and the activity of the gland; on whether inflammation or neoplasia is present and whether it can be confused with a more serious lesion. Most cause no trouble. Those in the stomach or duodenum may produce motor disturbances, pain or hemorrhage. It may precipitate intussusception in a Meckel's diverticulum. It may be the cause of hypoglycemia and neoplasm formation. Ectopic pancreatic tissue may occur in the mediastinum or ovary with teratomas. Pancreatic tissue, by x-ray may be confused with myomas or polyps. In the duodenum or stomach, it may be confused with peptic ulceration. If these tissues are seen during surgery or are causing symptoms, they should be excised. Partial gastrectomy may be needed for pancreatic heterotopia, if associated with peptic ulcer or marked gastritis.

A 30-year old man complained of epigastric pain for 10 years' duration. Distress was relieved by medical treatment. X-ray showed an ulcer. Four years later, pain returned, occurring 2 hours after meals. The pain was relieved by food. Four years later he developed severe epigastric pain with nausea, vomiting and hematemesis. Gastric analysis revealed a free acid of 42 and a total acid of 54 with no occult blood. X-ray: "rounded projection with a central cavity situated on the greater curvature of the stomach an inch proximal to the pylorus. Duodenal cap normal." Pre-operative diagnosis was gastric polyps or diverticulum. At operation an indurated area, a centimeter in diameter on the greater curvature was found. The mucosa was elevated with a central umbilication and in this area was a ductal opening into the stomach.

ANNULAR PANCREAS

A segment of pancreas, due to faulty embryologic development, may completely encircle the second part of the duodenum at the level of the major duodenal papilla. This is an annular pancreas. Symptoms depend on the presence and degree of associated duodenal pathology. Colicky pain in abdomen, nausea and vomiting may occur. When the degree of obstruction is minimal, symptoms may be delayed until adult life, and then may be due to secondary peptic ulceration of the first part of the duodenum.

Annular pancreas may be the site of acute or chronic pancreatitis. X-ray following barium meal shows a smooth narrowing of the second part of the duodenum. Surgical treatment is aimed at eliminating the duodenal obstruction by duodenojejunostomy or gastrojejunostomy. The annular segment should not be divided because of injury to the main pan-

creatic duct. A patient may also have fistula formation. With division, the obstruction may not necessarily be removed.

A 47-year old man complained of "poor stomach since 1918." He first noted chronic recurring, periodic epigastric pain. Appendectomy was done without relief in 1926. There was a gradual progression of symptoms until 1955. Examination then revealed tenderness in the epigastrium. X-ray showed a hypertonic stomach with no obvious defect except distortion of the antrum. Duodenum had no fill. Retention of 25 per cent of gastric contents developed in 6 hours. Gastric analysis showed 60 per cent free acid and 116 per cent total acid. The patient was given a Sippy diet, but was hard to control. The acid remained high and in time pyloric obstruction subsided. X-ray again revealed the duodenal cap to be filled with a remaining deformity at the base.

Fourteen years later he had a pain in the right upper quadrant which was aching and a gastric pain which was relieved by alkali and rest. Several months later he developed anorexia, abdominal pain, nausea and vomiting. No hematemesis or melena occurred. Pain became more constant and was not relieved by alkalies. Examination disclosed localized epigastric tenderness. The duodenal cap pointed posteriorly and there was a constant constricting deformity of the cap with narrowing in the upper duodenum. There was no gastric residue in 3 hours. Diagnosis of penetrating duodenal ulcer was made. At laparotomy, the duodenum was seen to be scarred and contracted. Beyond this point, the duodenum was encircled by an annular pancreas.

258 Reock Street

FDA Issues Reserpine Dosage Warning

Following is a letter from Ralph G. Smith, M.D., chief of the New Drug Branch in the Food and Drug Administration. This letter was sent to pharmaceutical manufacturers. It is reprinted here as a matter of obvious interest to all physicians.

When reserpine was first introduced the evidence suggested that it was a drug of low toxicity, with no contraindications, and with a wide range of safe dosage. As the drug has been used more extensively it has become apparent that reserpine is not the innocuous substance it was first thought to be. There are contraindications. The safe level for long term outpatient maintenance is lower than the originally recommended dosage schedule.

In the treatment of hypertension, or of anxiety states on an outpatient basis, it is the present consensus that the recommended maintenance dose should be 0.25 mg. daily. While doses up to 1.0 mg. daily may safely be recommended for the initiation of therapy, they usually should *not be continued for longer than a week. No substantial benefit is obtained by larger doses sufficient to compensate for the added hazard.*

Continued use of reserpine in doses of 0.32 mg. daily has been shown to increase gastric secretion and gastric acidity in a significant number of cases whereas daily doses of 0.25 mg. have not been shown to do so. Doses of 0.5 mg. daily for as short a time as two weeks produced this effect in most of the individuals tested and have resulted in massive gastrointestinal hemorrhage or perforation of an ulcer. More important, reserpine in daily doses of 0.5 or 1.0 mg. produces severe depression in a significant number of individuals, and *has precipitated a very considerable number of suicidal attempts,* some of them successful. Many of these depressions have been severe enough to necessitate long-term hospitalization in psychiatric institutions. Reserpine in daily doses above 0.25 mg. is contraindicated and in lower doses should be used with caution in patients with a history of mental depression, peptic ulcer or ulcerative colitis.

Reserpine tablets of 0.1, 0.25 or 0.5 mg. are suitable for hypertension and mild anxiety states. Reserpine tablets of 0.75 mg. potency or higher are suitable only for the psychiatric treatment of hospitalized patients under carefully controlled conditions, and the labels should state "For psychiatric use only." In view of the wide variety of dosage forms available it is important that the label declaration of the strength of the tablet should be very prominent, and preferably should be of a different color from the rest of the label to obviate any chance of 1.0 mg. tablets, for instance, being dispensed in error as 0.1 mg. tablets.

Historical Article • • •

EDWARD B. TYSON, M.D.
Ocean City

The Development of the Bronchoscope

In 1854 a singing teacher named Manual Garcia, curious to see vocal cords in action, tormented himself with hand mirrors until he was able to see his own vocal cords. From this inauspicious and, incidentally, non-medical, origin, laryngeal and bronchial endoscopy has evolved.

For centuries, men have shown scientific interest in the examination of internal body cavities. Speculae have been unearthed even in the ruins of Pompeii.[2]

The forerunner of anything like the bronchoscope was probably a small, highly polished metal mirror. No one knows when, and by whom, this instrument was first used. However, we do know that in 1743, Monsieur Leuret, a French accoucheur, developed a speculum, by the use of which he could remove polyps from the nose and throat by the additional use of ligatures. His instrument was a small, polished, metal plate which reflected rays of external sunlight in the direction of the operative field. It is not known just how successfully he could use this device.

Nearly sixty years later, in 1804, a Dr. Bozzini of Frankfort, Germany, made a small metal tube to illuminate the interior of the various body canals. He wrote a paper on this subject titled, "The Light Conductor, or a Description of a Simple Apparatus for the Illumination of Internal Cavities and Spaces in the Human Body." Bozzini was immediately dubbed a "quack," and he became the laughing stock of his immediate medical colleagues. His invention was disdainfully termed, "The Magic Lantern in the Human Body."

Bozzini's "Magic Lantern" consisted of two parts—one was a small square lantern which contained a candle, and two differently sized holes in opposite sides. The other part consisted of a number of tubes of varying sizes. The small hole in the side of the box was the eye piece, and the curved speculum was fitted into the opposite large hole in the side of the box. In the speculum, or laryngeal tube, were two small mirrors placed in the necessary functioning position at the downward bend of the tube. Although this apparatus proved to be of little value, it was a step forward.

In 1827, Dr. Senn of Geneva relied on a small mirror to view the upper part of the larynx. Because of its diminutive size, however, the mirror did not reveal enough to become of much use.

In 1829 Dr. Benjamin Guy Babington demonstrated a peculiar instrument at a meeting of the Hunterian Society of London. This contrivance consisted of two mirrors: one large, and one small. The smaller mirror reflected the image in the throat. The larger mirror was used to direct exterior sun rays inward on the smaller mirror. The patient was placed on a stool with his back to the sun. The small throat mirror, with attached tongue depressor, was held in the operator's right hand, and the light gathering mirror was held in his left hand. This arrangement was called a glottoscope. The instruments were similar to the ones used today.

Three years later, in 1832, Dr. Bernati of Paris, stated that he had been able to see the

vocal cords by using a peculiar double-tubed speculum. One of the tubes carried light down to the distal end in the throat. The other tube carried the image back up by means of an appropriately placed mirror securely fastened at the distal end of the latter tube. This instrument was made for him by a patient who was a skilled mechanic, and who suffered from severe "throat trouble." The mechanic's name was Celligue.

IT HAS been stated that Trousseau also had a similar tube, but because it was so awkward, and unpleasant to the patient, few people would permit him to use it on them.

In 1838 Baumés demonstrated a small mirror to the medical society at Lyons. This was to be used for the examination of the posterior nares and larynx. In 1840, a Scottish surgeon named Liston, devised a mirror attached to a slender handle. This was to be used in examining the larynx and vocal cords. He advised dropping the mirror into "fairly hot" water before using, to prevent the patient's breath from causing the mirror to become clouded during the examination. This small, but important principle, is still followed today.

Dr. Warden of Edinburgh, in 1848, produced a tube containing two prisms. One prism was for the purpose of reflecting light down the tube. The other prism (at the distal end) threw the light rays in another direction down on the glottis. This ingenious arrangement was too hard on the patient. Dr. Warden said, however, that with it he could see the glottis.

The first perforated head mirror may have been the one used by a Mr. Avery of London, in 1844. It consisted of a circular reflector with an observation hole in the center. The mirror was held to the operator's forehead by means of a strap.

Special attention should be paid to Manuel Garcia who saw his own vocal cords open and close, and who was also able to see a portion of the trachea.

Manuel Garcia, termed by some "the father of laryngology," was descended from a family of Spanish musicians. He was born March 17, 1805. He studied and, later, taught music. He became a professor at the Royal Academy of Music, and is said to have trained Jenny Lind.

Garcia, as a singing teacher, was interested in the function of the vocal cords, and he often wished that he could observe them. In 1854, by means of a hand mirror, and a smaller mirror on a slender handle, he was able to observe his own vocal cords in action. Others tried to do the same, but they were not successful. Garcia probably first succeeded because he was a trained singer and had absolute control of his own throat muscles.

Türck, of Vienna, attempted the same maneuver but failed. The next year, Czermak, who was Professor of Physiology in Pesth, Hungary, borrowed the mirrors from Türck. He said he was successful in seeing his own vocal cords. This feat started a temporary rivalry between Türck and Czermak.

Dr. Ephraim Cuttles and Mr. G. B. Clarke, of Massachusetts, designed a laryngoscope, fashioned after that of Bozzini.[2] They were unable to use it successfully.[2a]

UP TO this point, probably the only man who had seen into the trachea through the glottis by a direct method was Garcia. In 1875, Voltolini [3] observed the trachea and main bronchi through a tracheotomy wound. Later Prenwzek and Von Schrotter used a spectrum of the aural type, as did Hacher and Rosenheim.

In 1890,* Kirstein [4] developed the autoscope, a type of speculum without a mirror, through which a direct view of the larynx was obtained. In 1896, Brüning and Killian became interested in Kirstein's work, and in 1897 Max Thorner, of Cincinnati, became an ardent follower. In 1897, Killian first used an adaptation of Kirstein's autoscope converted into a closed tube, for direct tracheoscopy. A year later he applied it in direct upper and lower bronchoscopy. It is believed that in 1897 he was the first man to remove a foreign body lodged in the bronchus, by means of the bronchoscope.

By 1911, Killian [4] was ready to present a

*Some authorities set this date as 1895.

resume of his own work and the work of others in this field. This he did before the Society of the South German Laryngologists on May 29, 1911. The report was enthusiastically received. It was a real turning point in the progress of European bronchoscopy.

Bronchoscopic work was becoming more widespread. In Germany, there were Killian, Wild, Von Escher, Just, and Brüning. In 1905, 31 publications appeared on bronchoscopy in Germany. In Vienna, many were interested in this field. Pieniazel, Nowatony, Chiari, and Kahler were enthusiastic investigators. In America, Coolidge started this type of work as early as 1899, but it was not until 1904 did activity really begin under the direction of Fletcher Ingals, Scmyzer, Jackson, Mosher, Mayer, Yankauer, Clayton, Elsbery, and other.

In 1898, at the Massachusetts General Hospital in Boston, Dr. Algernon Coolidge, using an open urethroscope, a head mirror, and reflected sunlight, removed a portion of a hard rubber tracheotomic cannula from the right bronchus of a 22-year old man. This was removed through an already present tracheal fistula. In 1908, twenty-eight papers on direct examination of the air passages were published in America.

PIONEER workers in France were Jacques, Garel, and Cavaillon in 1901; Mouse in 1902, and Texier, Termoyer, and Guisez in 1903. Special mention should be made of Siebermann and Noger in Switzerland, and Tapia, Batey, and Batella in Spain.

Bartoux [6] stated that Killian used Voltolini's and Kirstein's lateral autoscope. This was introduced into the trachea after anesthetization of the larynx. A tube was then slid through the autoscope into the trachea, where, after some manipulation, Killian was able to examine the trachea, its bifiurcation, and also the branches of the bronchi of the superior, middle, and lower lobes. Killian also reported a case where he removed a large vulcanite tooth plate by cutting it to pieces with the aid of special pincers.[7]

In 1908, Bourguet [8] described Brüning's bronchoscope. This instrument had the usual handle at right angles to its barrel; but on the handle, there was an electric lamp and also a mirror arrangement. The mirror reflected the light rays down the barrel of the bronchoscope. This combination, he termed the electroscope.

Bourguet also mentioned various types of punches, curettes, and knives, all held on long, thin handles and operated by hand-grips at the proximal end. These were used for various maneuvers in the trachea and bronchi.

Brüning used a spatula and a tube. The spatula was carefully pushed into the larynx between the vocal cords, and the bronchoscopic tube was then slid into the spatula, and then introduced into the trachea. The inner tube had calibrations on it to indicate to the operator the depth to which the tube was being inserted.

Guisez [9] described a type of bronchoscope which he devised. It was of the conventional type, but it had a funnel on the proximal end, painted black inside, to collect the light rays which were reflected into the funnel from a combined mirror and light arrangement, which was attached to the operator's forehead.

THE introduction of the tube was facilitated by a semi-rigid bougie attached to the distal end of the tube. This flexible end was supposed to aid in guiding the rigid bronchoscope into its proper position. However, it was not particularly successful. Guisez also described an esophagotome for operative procedures, and also a type of forceps for extraction of foreign bodies. At this point, we may also mention the Schoonmaker instrument which made use of an extension tube. This did not prove to be of any great use.

Kahler,[10] another pioneer in the bronchoscopic world, stated that direct laryngoscopy was becoming indispensable. The wide use to which these instruments could be put to was slowly becoming appreciated. The bronchoscope at this time was not only being used for removal of foreign bodies, but also for observation, examination, and diagnosis of pathological conditions of the bronchi.

It was about 1904, that Chevalier Jackson, dean of American bronchoscopy, brought forth

a bronchoscope which had a small light at the distal end. This light was about the size of a grain of wheat, but its illuminating effect was very great. About the same time, he also developed an instrument with an auxiliary tube for lighting, and an additional tube for draining.[11] A few years earlier, he described a tube to be passed inside the bronchoscope, but he remarked that this was like a "Bull-dog on a chain, straining for a bone out of reach." Therefore, he suggested the costrophrenic type of instrument to be inserted to a greater depth.[12]

During this period of a few years, he also constructed a direct laryngoscope which proved to be useful in the diagnosis of laryngeal conditions, and to facilitate the passage of the bronchoscope. But even with all of this remarkable advancement, bronchoscopy was still a relatively unknown science. In 1909, Jackson reported a case of a child who had died from swallowing a foreign body. When the attending surgeon was asked why he hadn't used the bronchoscope, he replied, "What is that?" Jackson stated there was no further excuse for thoracotomies with their attending high mortality.

In 1913, appeared the controversial article written by Dr. Richmond McKinney.[13] McKinney condemned Jackson's apparatus, because he believed the "grain of wheat" light to be of little value. He said that it broke or loosened easily, and the light was often obscured by pus. He added that the electroscope of Brüning was far superior. This paper in itself did not prove much, but it did indicate that more interest was being aroused in bronchoscopy. Yankhauer stated that Fletcher Ingals had definitely proved Jackson's instrument to be superior.[14]

Interest in the art of bronchoscopy was carried to Canada by McDonogh, Wishart, and Boyd. In 1909, McDonogh removed a foreign body from the bronchus of a child. Wishart stated that he observed Killian and Jackson in Philadelphia in 1907, and later he visited Killian's Clinic and studied under Killian's first assistant, Dr. Von Eschen.[15]

In 1908, Guisez, in France, told of removing a foreign body from a patient, by means of the bronchoscope and crude pincers on the end of a long rod.[16] In the same year, Halstead described 18 examinations or operations, using the bronchoscope, on 14 patients whose ages varied from one day to 70 years.[17]

By 1912, the bronchoscope had become an accepted instrument. Chevalier Jackson was working in Pittsburgh and men came from all parts of the world to observe his technic. Jackson often practiced on dogs and cadavers to perfect his routine.[18]

By 1912, most of the basic principles had been laid down. Since then, although there have been many innovations, the primary factors in bronchoscopy have remained stable. To be sure, many types of forceps for grasping peculiarly shaped foreign bodies have been brought out. Again, a suction tube in the form of a bronchoscope was introduced by Dr. Meyerson.[19] This used the vacuum (negative pressure) method to hold objects to the end of the tube for withdrawal from the bronchi.

In England, Sir William Milligan presented a bronchoscope with an extension tube. The extension was adjusted like the barrel of a microscope. Dr. Gabriel Tucker also developed an extension bronchoscope so that he might go more deeply into the bronchi.[20] He also made a peculiar and efficient type of forceps for the removal of beads which are especially difficult to grip.

Wolfson and Schloss [21] spoke of a "telescopic bronchoscope" equipped with a series of lenses which enabled the operator better to see the upper and middle lobe bronchi. Mouse [22] suggested a mirror adjustable to any angle, to be placed through the direct endoscope between the vocal cords, and thus better observe the subglottic region. Smythe[23] then described special forceps for the easier removal of staples.

The bronchoscope is sometimes manipulated under the guidance of the fluoroscope. Dr. Ingals described cases where the foreign body was located by use of the fluoroscope and then removed.[24] Hundreds of additions and innovations have been suggested or added to the bronchoscope. Some were of value; some were

merely refinements of already established principles.

Today, the bronchoscope is an established diagnostic and operative principle. In Philadelphia alone, there are five established teaching chairs of bronchoscopy. Chevalier Jackson, at one time, held all of these chairs simultaneously.

Some years ago, Philadelphia was the greatest bronchoscopic center in the world. This was probably due to the distinguished presence of the Doctors Jackson, Clerf, Gabriel Tucker, and other acknowledged leaders in this field. Today, of course, the art has spread to many medical centers in different cities; and there are tremendously skilled experts in these places. However, Dr. Jackson and his group in Philadelphia are probably still considered the international authorities on the subject.

It is revealing to see how such magnificent progress has been made in the development of a marvelous life-saving instrument. Its beginning was so humble. It was in part, based on the fact that a renowned singing teacher wished to see his own vocal cords. Every day new modifications, improvements, and uses are being presented.

740 Central Avenue

A bibliographic listing of 32 citations appears in the author's reprints.

Thanks for Small Favors

The consuming problem of public relations in medicine best starts with the patient himself, and patients are much more impressed by seemingly small acts of consideration and comfort than by matters of technical brilliance about which they are not aware.

—Maxwell Boverman in *Clinical Clippings.*

Colostomy Care Book

The American Cancer Society publishes a "Book of Information" on the care of a colostomy. This may be found useful by physicians for distribution to patients following an operation. The book shows how to avoid difficulties and embarrassment and explains methods of care. It suggests effort on the part of the patient to accept the strange, new situation, and impresses the fact that there should be no resentment about the colostomy as it is a small price to pay for a life. It also urges the patient to be confident and trusting in the physician, consulting him when special problems arise.

Copies may be obtained from the American Cancer Society, New Jersey Division, Inc., 9 Clinton Street, Newark.

Internal Medicine Society Being Organized

A New Jersey Society of Internal Medicine is being organized. This will be a chapter of the rapidly growing American Society of Internal Medicine. The New Jersey Society held a preliminary meeting on December 6, 1956, and selected a provisional steering committee consisting of Drs. Frederick Hnat (Union County), Sherwood Vine (Mercer County), Leslie Townsend (Union County) and Peter Warter (Mercer County). Dr. Vine is provisional chairman. All internists in New Jersey are asked to obtain further information by writing to Dr. Sherwood Vine at 208 West State Street in Trenton.

Trustees Meeting: November 1956

At its November 18, 1956 session, the Board of Trustees:

—Heard a report on the federal government's "Medicare Program" by Dr. McCall. With reference to the schedule of benefits applicable to this area, it was found that in the final *Schedule* there will be no fee lower than the corresponding one in the Current Blue Shield contract. In a great number of items, the *Schedule* will run at a higher level. The full schedule must be held as classified material until the final contract has been signed.

The Society's legal counsel, Mr. Backes, and representatives of Medical Service Administration also met with government representatives to negotiate the necessary contract under the Medicare program. The government representatives stated that it appeared to them that Medical Service Administration is not equipped nor has it the facilities to perform the functions necessary to administer the provisions under the contract. It was the policy of the Army to negotiate only with organizations presently performing the type of duties and services which would enable them immediately to assume the functions required by the government under its contract. It was suggested that M.S.A. might be named as the designated Fiscal Administrator, provided a new article was included in the contract which would provide that M.S.A. would subcontract all the duties and functions of the Fiscal Administrator to Medical-Surgical Plan. This will be presented to the Boards of the New Jersey agencies concerned. The Government representatives stated that an advance payment could be made to get the program under way. It was reported by Dr. Schaaf that the State Commissioner of Banking and Insurance would allow M.S.P. to be the fiscal agent but that such a program would have to be limited to medical fees only—not hospital fees, not dental fees, no other fees except medical. H.S.P. cannot under its enabling act be the direct contractor, but it may be a subcontractor. M.S.A. is permitted, under its amended charter, to receive money from any government source and pay for any fees—medical, hospital, dental, etc. It is natural that M.S.A. should be the fiscal administrator.

The Board of Trustees reaffirmed its action of September 9 in having Medical Service Administration of New Jersey serve The Medical Society of New Jersey as its fiscal administrator in the Medicare Program.

Dr. McCall and Mr. Backes explained that $50,000 will be required to get the program under way before returns begin to come in from the government. M.S.A. does not have the necessary funds, and it will be necessary for the Society to provide the funds or obtain funds from the government.

It was finally agreed that our Society obtain an advance payment putting up government bonds as collateral, reserving the right to replace these with a surety bond if desirable.

—Heard a proposed revision of the A.M.A.'s *Principles of Ethics*. The Board voted to oppose this revision in its present form for reasons developed by our Judicial Council. In this connection, the following resolution was adopted for forwarding to the A.M.A.

Whereas, the present *Principles of Medical Ethics of the American Medical Association* are definite and binding, and the proposed principles are indefinite, not binding, and therefore ineffectual; and

Whereas, it is of the nature of ethical principles that they necessarily embody fundamental moral considerations which must be deferred to and observed by *all* for the preservation of sound social order; and

Whereas, if each individual physician is to judge for himself concerning the adequacy or inadequacy with which he lives up to these ethical principles, there is no possibility or use in organized medicine for judicial bodies of any kind; and

Whereas, ethical principles must be universally binding or they are impotent, and they must have —as in the natural order they do have—the impact and the effect of law, the natural moral law; therefore be it

Resolved, that, having carefully studied the proposed revision of the *Principles* and found them unsatisfactory, incomplete, and in disregard of fundamental moral responsibilities and inherent personal rights and privileges of the physicians, The Medical Society of New Jersey urges that said proposed revision in its present form be rejected.

—Agreed to cooperate with the Pharmaceutical Association in a Child Safety Program.

—Appropriated $25 as a donation to the National Society for Medical Research.

—Adopted a provisional schedule for the 1957 Annual Meeting.

—Supported an opinion of the Judicial Council frowning on the extension of hospital privileges to osteopaths. The Council stated that in light of the provisions in the Principles of Medical Ethics of the A.M.A. which state: " . . . All voluntarily associated activities with cultists are unethical . . ., " and the Report of the A.M.A. Judicial Council dealing with Osteopathy, submitted to the House of Delegates at the 1955 A.M.A. Boston Clinical Meeting, the Judicial Council unanimously concluded that association with osteopathic physicians as co-equals, within or out of hospitals, contravenes the "Principles of Medical Ethics" of the A.M.A., and is therefore unethical.

—Decided against passing judgment on medical testimony in workmen's compensation cases. Dr. Henry Brodkin, medical director of the Department of Labor had asked the Society to judge whether certain medical testimony was "in line with the accepted thinking of the medical profession" in a case of this kind. This request was referred by the Board to the Judicial Council. The Judicial Council suggested that the request does not lie within its jurisdiction. It is not the responsibility of the Council to supply medical opinion, such as seems to be solicited in Dr Brodkin's communication. The Judicial Council is of the opinion that Dr. Brodkin should seek such opinion from individual members of the profession recognized as outstanding in the fields involved. The Judicial Council also holds that if this inquiry involves a complaint against the physician on grounds of unethical or unprofessional conduct, the proper initial recourse is to the Judicial Committee of the physician's county medical society, which will hear a complaint—originating with Dr. Brodkin or any other person—on specific charges directed against the physician.

—Supported Dr. Hurff in his unwillingness to release certain statistical information to be used by companies competing for insurance. Our committee on medical defense and insurance reported that its chairman was being "pressured" by a group of doctors who would like to secure inside statistical information on the Society's plan of insurance experience over a period of years. Dr. Hurff suggests that the material supplied to the committee each year is confidential. While the committee is always ready to accept another insurance plan if it is better than the present plan, the chairman does not feel he should give out information to be used in competition with the present plan; that he has no right to break down the confidence that exists between the insurer and the committee. Dr. Hurff requested the Board's opinion on the matter. The Board supported Dr. Hurff.

Dr. Jaeckle Elected to Eye Foundation

Dr. Charles E. Jaeckle of East Orange, a member of The Medical Society of New Jersey has been elected secretary of the newly established National Medical Education for Eye Care, a nonprofit institution organized by ophthalmologists to provide American ophthalmology with an agency to present to the public and to fellow physicians information on the care and treatment of the eyes.

Dr. Ralph O. Rychener of Memphis is president of the Foundation; Dr. Edwin Forbes Tait of Norristown, Pa., vice-president, and Dr. Charles E. Jaeckle of East Orange, N. J., secretary-treasurer.

In a statement announcing the Foundation's establishment, Dr. Rychener declared: "American ophthalmologists have long recognized an urgent need for an organization to interpret the basic professional and scientific standards of good eye care for the American people, both to our fellow physicians and to the people whom we serve.

"The National Medical Foundation for Eye Care will help the people understand the educational qualifications and the professional functions of physicians specializing in ophthalmology, and the functions of related technical and ancillary personnel who assist them.

The Foundation is now enrolling its charter membership, and physicians interested in eye care may now become charter members. Application is made through Dr. Charles E. Jaeckle, at 136 Evergreen Place, East Orange, N. J.

Proposed Amendment to Constitution

The following proposed amendment to the Constitution was approved by the House of Delegates at the 1956 Annual Meeting and will be presented for final approval at the meeting in April, 1957. The proposed amendment is herewith published in full in compliance with the Constitutional provision to that effect.

ARTICLE VI—BOARD OF TRUSTEES

Delete Article VI of the Constitution and replace Article VI with this amendment:

Section 1. The Board of Trustees shall be the executive body. It shall be composed of the immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and twenty-one (21) members. Each member shall be elected from and by his component county society prior to the annual meeting of the House of Delegates. Each member shall be elected for a term of three (3) years, such term to commence upon the expiration of the term of the former incumbent. The term of office of seven members shall expire annually.

Section 2. Provided that within thirty days following the adoptions of these amendments, the first seven (7) counties alphabetically, from Atlantic through Essex, shall elect for one (1) year, the second seven (7) counties, from Gloucester through Morris, for two (2) years, and the third seven (7) counties, from Ocean through Warren, shall elect for three (3) years. Thereafter, at the expiration of those terms each Trustee shall be elected for three (3) years. After two (2) years Article VI, Section 2 shall be automatically deleted from the Constitution without further amendment. Members of the present Board of Trustees shall hold office until their successors are elected.

Section 3. Any member as classified in Article VI, Section 1, may be elected a Trustee for a maximum of three (3) full terms provided however that if the first two (2) elected terms are successive there shall be a lapse of at least one (1) year between expiration of the second and commencement of the third terms.

Section 4. In the event that the office of any member becomes vacant for any reason the component county society wherein the vacancy exists shall elect a member within 90 days to fill the unexpired term.

Mr. Nevin Named to Medical Research Program

Three medical society executives, including our own Mr. Richard Nevin, and three medical educators have been named to advisory committees of the National Disease and Therapeutic Index medical statistical research program. George Morris Piersol, M.D., Dean, Graduate School of Medicine, University of Pennsylvania; J. Murray Kinsman, M.D., Dean, School of Medicine, University of Louisville; and George A. Wolf, Jr., M.D., Dean, College of Medicine, University of Vermont, constitute the committee of medical educators; and John Hunton, Executive Secretary, California Medical Association; Richard I. Nevin, Executive Officer, The Medical Society of New Jersey and William H. Bartleson, Executive Secretary, Jackson County (Mo.) Medical Society, constitute the committee of medical society executives.

The National Disease and Therapeutic Index is designed to provide continuous statistical information for study of the reasons why patients see doctors and the types of treatment they receive. The absence of reliable data on morbidity and therapeutics, and the potential value of such data led to the present program which has the support of leading pharmaceutical firms. Some nine hundred doctors in twenty-seven representative areas are each making a full report of all patients seen during specified periods. The new committees have been established to provide for continuing study of the effectiveness of the project in providing eventual aid to: medical educators in planning and revising curricular; medical investigators in determining the directions to be taken in research; practicing doctors in efforts directed toward preventive medicine; health organizations in development of future programs; and pharmaceutical manufacturers in research and product development designed to meet current and future needs.

Announcements • • •

General Practice Assembly

The American Academy of General Practice will meet from March 25 to 28 in St. Louis. The doctors will hear outstanding speakers discuss such subjects as infertility, poliomyelitis vaccination, and the "neglected" pediatric areas, the eyes, ears, and feet. They will visit 60 scientific and 260 technical exhibits.

Dr. I. S. Raydin, professor of surgery at the University of Pennsylvania, will moderate a panel discussion on surgery for GPs. Dr. Philip Thorek, professor of surgery at Cook County Graduate School will discuss intestinal obstruction. Other surgeons will highlight advances in vascular, thoracic, and brain surgery. One afternoon will be devoted to a review of procedures that assure birth of "healthy babies" from "well mothers."

For details, write to American Academy of General Practice, Brookside St., Kansas City 12, Mo.

Ophthalmology Meeting

April 7 through 10 has been fixed as the time for the Pan American Ophthalmological Congress at the Statler in New York. An extraordinary program of lectures, case presentations, exhibits, demonstrations and seminars has been planned. For details, write to Dr. Frank H. Constantine, 30 West 59 Street, New York 19, N. Y.

Resuscitation Courses

On the first Friday and Saturday of each month, a practical course in resuscitation, hypoxia and prevention of asphyxial deaths is given under the auspices of the National Resuscitation Society. This is an intensive, practical, instantly utilizable course. Tuition fee is $50. Courses are given in New York City. For more details write to National Resuscitation Society, 2 East 63 Street, New York 21, N. Y.

Surgeons Meet in West Virgina

The mid-Atlantic regional meeting of the International College of Surgeons will be held at The Greenbrier Hotel, White Sulphur Springs, West Virginia, February 10 to 13, 1957. The program calls for professional papers on each of these mornings leaving the afternoons free for entertainment. There will be one evening meeting, a dinner one, with an outstanding speaker. The Greenbrier will be glad to furnish any information in regard to reservations.

Heart Disease and Your Way of Life

Under this intriguing title, Dr. Paul Dudley White will deliver the Biggs Lecture on Thursday evening, February 7, 1957. The time: 9 p.m. The place: New York Academy of Medicine at 2 East 103 Street. You are invited.

Rehabilitation Planning Center

A Rehabilitation Center Planning Institute will be held at the Morrison Hotel in Chicago from February 25 to March 1. The Institute, which is open to all persons is conducted under a grant from the U. S. Department of Health, Education, and Welfare.

The keynote address on February 25 will be delivered by Dean W. Roberts, M.D. on "The Evolution of the Rehabilitation Center as a Social Force." Miss Mary E. Switzer, Director, Office of Vocational Rehabilitation, will close the proceedings on March 1, with an address on "The Forward Look in Sound Planning for the Rehabilitation Center."

Other featured speakers include Henry Kessler, M.D., of New Jersey; E. B. Whitten, executive director, National Rehabilitation Association; and Donald A. Covalt, M.D., associate director, Bellevue Medical Center Institute of Rehabilitation and Physical Medicine.

For registration or for additional details, write to William F. Stearns at 5 Franklin Ave., Saranac Lake, N. Y.

American College of Physicians

The 1957 session will be in Boston, April 8 to 12. For details, write to Mr. Edward R. Loveland, 4200 Pine St., Philadelphia 4, Pa., General Manager. In 1958, the convention will be here in Atlantic City, N. J., from April 28 through May 2.

Jet-Atomic Medicine

Medicine in the jet-atomic age of flight will be the central theme of the meeting of the Aero Medical Association in Denver, May 6, 7, and 8.

The scientific program will include reports on emergency escape from high performance aircraft, developments in airline passenger comfort and safety, and current research in space satellites. The American Board of Preventive Medicine will conduct examinations for certification in aviation medicine in Denver from May 3 to 5.

Dr. Nolie Mumey, Denver, is general chairman of the meeting. Speakers desiring to participate in the scientific sessions should send the title of the paper and a 150-word abstract to Dr. E. J. Baldes, Mayo Clinic, Rochester, Minnesota.

Psychiatric Residencies Available

The Veterans Administration Hospital at Lyons has available residencies in psychiatry for a one, two, or three year period which are fully accredited by the American Board of Psychiatry and Neurology. The training program consists of lectures, conferences and seminars under the direction of the Department of Psychiatry, New York Medical College, and offers intensive training, both intramurally and through rotation in special hospitals and clinics in the adjacent area. There is, in addition, a series of extensive guest lecturers as well as an Annual Institute at the hospital. Training may commence at any time.

Cincinnati's Medical Centennial

The Academy of Medicine of Cincinnati invites all physicians and their families to its 100th Birthday Party, February 27 through March 5, 1957. A Health Museum and Exposition is being established in Cincinnati's Music Hall. Health and scientific exhibits, representing medicine, hospitals, research centers, public health, nursing, pharmacy and industry will be displayed. Notable among these will be an atomic energy exhibit entitled "Atoms for Peace." Here you can see "Juno," a full-sized, activated manikin, graciously lent by the Dominican Republic. Juno is operated electrically, and with concurrent recorded narration, will demonstrate blood vessels, bones and organ structures of the body.

Professor Reginald McGrane, Chairman of the Department of History, University of Cincinnati, has prepared a one hundred year history of the Academy of Medicine, entitled "The Doctor's Forum." Copies of this volume will be available at the Centennial Exposition. The Cincinnati *Journal of Medicine* will have a Centennial Edition.

Vacancies for Physicians

General practitioners are acceptable for several vacancies on the psychiatric and neurologic staff of the VA Hospital, East Orange. Waiver of age limit will be considered. GP's will be trained for the work. Salary depends largely on experience and qualification. Communicate with Director, Professional Services, VA Hospital, East Orange.

Electrocardiography Course

Wednesday evenings from 7 to 9 p.m., a course in the interpretation of the electrocardiogram will be given by New York University, New York City. The first meeting is on February 6, the last on May 22. For registration and for further information write to New York University Medical Center at 550 First Avenue, New York 16, N. Y.

County Society Reports . . .

Bergen

The regular meeting of the *Bergen County Medical Society*, held November 13, 1956, at Bergen Pines Hospital, Paramus, was called to order by William T. Knight, M.D., president, at 9:20 p.m. with 89 members present.

Newly elected regular members were asked to come forward to meet President Knight and receive certificates of membership and identification cards.

The Secretary read the following names, which had been approved by the Executive Committee for election:

To Associate—

R. D. Eisenhauer, Gerda S. Hillyer, Robert E. Kahn

To Regular from Associate —

Joseph J. Gallagher

To Regular by Transfer —

Alvin Robins, Howard C. Tobey

All were elected to the grade indicated.

The Secretary read a telegram sent to Dr. Dickinson W. Richards by President Knight on behalf of the Society, congratulating Dr. Richards on winning a share of the Nobel Prize in Medicine. He also read Dr. Richards' note of appreciation acknowledging our telegram.

Dr. Susinno introduced Dr. C. H. C. Beakes, who in turn presented Dr. Walter Lawrence, Jr., of the Department of Physiology at Memorial Center for Cancer and Allied Diseases, New York City. Dr. Lawrence spoke on "An Appraisal of Recent Developments in Fluid and Electrolyte Management."

CHARLES P. CAMPBELL, M.D.
Reporter

Camden

The regular monthly meeting of the *Camden County Medical Society* was held on December 4, 1956 in the meeting rooms of the Society, with Dr. George P. Meyer, president, in the chair. Drs. William G. Field and William T. Goulburn were introduced to the Society after taking the membership oath and signing the roster.

Dr. Irvin E. Deibert introduced the scientific program and acted as a member of the panel. With the Honorable Thomas M. Madden, United States Federal Court Judge, as Moderator, the panel consisted of Mr. William G. Bischoff and Mr. Thomas S. Connery, Jr., Attorneys at Law, and Dr. A. M. K. Maldeis. The program was an interesting medico-legal discussion of hypothetical questions posed to the panel.

Dr. Helen F. Schrack, Historian, reported progress on the history of the County Society which she is compiling.

EUGENE H. KAIN, M.D.
Reporter

Cape May

A regular meeting of the *Cape May County Medical Society* was held on November 27, 1956, at which time the Constitution and By-Laws of the Society were discussed and approved.

The Society will publish this Constitution in booklet form to be sent to each member and accepted applicant.

This concludes the work of several months in framing this report.

ROBERT G. STINEMAN, M.D.
Reporter

Gloucester

The November 15, 1956 meeting of the *Gloucester County Medical Society* was called to order by Dr. James Kehler, vice president, at the Woodbury country club. The name of Dr. Clifford Montgomery was presented for membership and accepted. Dr. Clarence W. Jaggard was introduced to the society.

Dr. Kehler welcomed members of the Gloucester County Bar Association as guests, and pointed out that this was the first meeting of its kind in Gloucester County in which both legal and medical societies participated. Dr. Kehler then introduced Mr. Frank Sahl, president of the Bar Association, who addressed a few remarks to the group.

Mr. S. Walker Foulkrod, Jr., a Philadelphia attorney—was the speaker of the evening. He offered his belief that it is a moral obligation of a physician, who helps a patient attain physical well-being, to aid his financial welfare and be willing to appear in court when needed.

Following the meeting members of both societies enjoyed refreshments.

ROGER D. LOVELACE, M.D.
Reporter

Middlesex

The regular monthly meeting of the *Middlesex County Medical Society* was held at Roosevelt Hospital, Metuchen, Wednesday evening, November 21, 1956. Dr. Sidney Becker, the president, convened the session at 9:00 p.m. Our guest, Dr. Garfield G. Duncan, Clinical Professor of Medicine, Jefferson Medical College, spoke on "The Practical Management of Diabetes Mellitus."

Dr. Becker then opened the business session by commenting on the poor attendance at the monthly meetings. It is impossible to have so few members transact the affairs for the entire group. If each member would bring one other physician with him we could have a respectable attendance.

Dr. Moolten announced that the selected site for the headquarters for the Middlesex County Blood Bank for Civil Defense would be New Brunswick. Dr. Calvin moved that the Middlesex County Medical Society again express dissatisfaction with the proposed revision of the Code of Ethics by the A.M.A. This was seconded and passed.

Drs. Paret and Gadek discussed the "Diabetic Detection" Week Program. New Brunswick and Perth Amboy were well covered with the fine cooperation of the druggists.

The following were elected to membership:

To regular membership—by transfer from the Somerset County Medical Society—Dr. Samuel Cogan, New Brunswick.

To regular membership from Two-Year Associate membership—Drs. T. A. Balanski, Perth Amboy; John Dragan, New Brunswick; Severin T. Golojuch, South River; Edward Partenope, Colonia and Eugene J. Gosselin of Rahway.

To two-year period of Associate membership—Dr. Mary Ellen Kennedy, New Brunswick.

Dr. Slobodien announced that the Board of Trustees of The Medical Society of New Jersey ruled that one of our doctor's qualifications for membership was not satisfactory to The Medical Society of New Jersey or the American Medical Association since he was licensed to practice as a doctor of osteopathy. His M.D. Degree was obtained without meeting the necessary four years' attendance at a recognized school of medicine A motion was made for the Secretary of the Society to notify the doctor that his membership has been discontinued because he is licensed to practice as a doctor of osteopathy.

Dr. Sandella then announced that the County Medical Society had been approached by a public relations man who proposed writing six bulletins on the life and problems associated with medicine and becoming a physician. He would be active in the press and radio. He asked an annual retainer of $1250. The amount would be derived either from increased assessment to each member or increased advertisements in the *Bulletin*. The proposal was laid on the table.

MORTON M. KLEIN, M.D.
Reporter

Monmouth

Under the chairmanship of Dr. John Hardy, its President, the *Monmouth County Medical Society* held its regular meeting on November 28, 1956 at Monmouth Memorial Hospital.

A proposed amendment to the constitution of the Society establishing a "military courtesy membership" was read. This would allow commissioned officers of the armed forces who are graduates of a grade A medical school to obtain non-voting membership in our Society while temporarily located in Monmouth County.

Dr. Margaret S. Norris, Spring Lake Heights, was granted the status of Associate Membership.

The Society was honored by the presence of Dr. Milton Halpern, Chief Medical Examiner for the City of New York and Professor of Medical Jurisprudence, New York University College of Medicine. During the scientific session, Dr. Halpern spoke on "Investigation of Sudden Unexplained Deaths." His illustrated talk was most interesting and enlightening.

DONALD W. BOWNE, M.D.
Reporter

Morris

The *Morris County Medical Society* met for its November 15, 1956 meeting at Warner Chilcott-Auditorium in Morris Plains.

Dr. Robert Zimmerman chaired the meeting in the absence of the president. Speaker of the evening was Dr. Max Chamlin, Professor of Ophthalmology at the Albert Einstein Medical College, who addressed the society on ophthalmology in general practice. The talk was received enthusiastically by the members and a question and answer period followed. Refreshments were served after the meeting adjourned.

ALBERT ABRAHAM, M.D.
Reporter

Salem

A discussion of peripheral vascular disease featured the November 15, 1956 meeting of the *Salem County Medical Society* at the DuPont-Pennsgrove Country Club. Principal speaker was Dr. Daniel Marino, Chief of Peripheral Vascular Disease at Hahnemann Medical College. His discussion, entitled "Current Trends in Peripheral Vascular Disease," was concerned chiefly with the differential diagnosis among Raynaud's Disease, Buerger's Disease, peripheral arteritis and arterial embolism.

It was decided to send a letter to local boards of health reminding them of the advisability of holding clinics in the near future, to give third injections of poliomyelitis vaccine. Letters will be sent to local newspapers asking for their help in reminding the public that now is the time for third injections of the vaccine for those who received one or two injections earlier this year, and that it is also the time to begin poliomyelitis immunizations for everyone who hopes to complete their three-injection series before next summer. Emphasis will be laid on the fact that poliomyelitis vaccine is now available to everyone of every age.

The members present agreed to administer the vaccine in their offices without cost to anyone who had not yet had two injections and who stated that they were unable to pay for the injections. It was also agreed that the Society would cooperate with the local boards of health in the clinics for giving third injections which were proposed by the Society.

W. L. SPROUT, M.D.
Reporter

Woman's Auxiliary • • •

Essex

The Executive Board meeting of the *Woman's Auxiliary to the Essex County Medical Society* was held on November 12, 1956, at the home of the president, Mrs. Harry DiGiacomo. Thirty members attended to discuss the final plans for the Poinsettia Ball.

On November 29, the Woman's Auxiliary, in cooperation with the American Cancer Society, the Speaker's Bureau of the Essex County Medical Society and the *Newark Evening News*, presented a program of special interest to women. Two timely films were shown. Dr. Wade Miller of East Orange moderated a discussion and answer period before an audience of more than 100 women. Two of the hostesses from the Woman's Auxiliary were Mrs. Asher Yaguda, Chairman of the Community Health Committee and Mrs. Harry DiGiacomo, President of the Auxiliary.

Guests of honor at the gala Poinsettia Ball, held on December 8 at the Military Park Hotel were Mrs. Harry DiGiacomo, President of the Woman's Auxiliary, Dr. Marcus H. Greifinger, President of the Essex County Medical Society, Dr. Edward G. Gullord, Advisor to the Woman's Auxiliary, Dr. Ronald F. Buchan, President of the Academy of Medicine and Dr. Charles L. Brown, Dean, College of Medicine, Seton Hall, Jersey City. Dr. Harrold A. Murray acted as master of ceremonies.

The Choral Group, under the chairmanship of Mrs. Harold Grubin and directed by Mr. John Murphy of West Orange entertained at the Poinsettia Ball.

Scheduling of Booth Coverage for the Christmas Seal drive at Kresge Department Store was completed. Mrs. Michael Pierce, chairman of Booths, and her co-chairman, Mrs. Carlyle W. Schumacher, announced that 27 volunteers from the Auxiliary will man the booth from December 10 through December 22.

Mrs. Frank D. Bellucci, Membership Chairman, has announced that the following women have been elected to the Auxiliary: Mrs. Anthony R. Caputo, Belleville; Mrs. Martin Fischbein, Irvington; Mrs. Marcus T. Block, Newark; Miss Jane A. Block, Newark; Mrs. Paul Russomanno, Newark; Mrs. Robert E. Farabough, Nutley; Mrs. Anthony Coppola, Millburn; Mrs. Robert K. Spiro, Bloomfield; Mrs. Joseph S. Berman, West Orange; Mrs. Elliott Middleton, Jr., Montclair. We are happy to welcome these new members.

MRS. E. SEIFERT, Chairman
Press and Publicity

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Electrocardiography. By L. Wolff, M.D. Ed. 2. Pp. 342. Philadelphia, 1956. Saunders. ($7.00)

The first edition of this excellent book was written in 1950 at which time its clarity and scope of presentation were far above average. The present volume is almost 200 pages longer than the first edition. This is due in part to further elucidation of electro-physical problems involved in both scalar and vector electrocardiography in view of our advances in this field. More important is a new section on the arrhythmias which is well written though succinct and will be of great help to all who are confronted with this common problem.

This new edition of Dr. Wolff's book is more than just a bit of re-editing and rearrangement o material. It is much more inclusive than the first edition as well as more up to date, especially in its orientation to vectorcardiography. Its clarity makes it valuable for the general practitioner as well as the internist.

ARTHUR BERNSTEIN, M.D.

Medical Writing. Edited by Felix Marti-Ibanez, M.D. New York, 1956. M.D. Publications. Pp. 63. ($3.00)

You won't learn how to write a medical article by reading these 5 essays. But you will have an enjoyable hour or two of stimulating reading. Henry Sigerist opens with some general advice on culture. He suggests that you set your alarm clock 10 minutes earlier and read a poem each morning. Also, he advises you never to read a newspaper until you have read at least 50 pages of a "worthwhile" book. This is followed by an article by Hans Selye on misinterpretation of scientific experiments. Most of his examples are from the field of endocrinology and not readily applicable to other specialties. Then comes a 2-page item by Walter Alvarez which packs in several paragraphs of practical pointers. A British medical editor named Hugh Clegg follows with some general remarks about writing style. The last third of the booklet is a gracious and witty dissertation on the physician as a man of letters. If you don't mind paying $3 for a 63-page, soft-cover booklet, you will find this a pleasant and provocative, even if not very practical production.

HENRY A. DAVIDSON, M.D.

Bellevue is My Home. By Salvatore R. Cutolo, Arthur Gelb and Barbara Gelb. Doubleday, Garden City, 1956. Pp. 316. ($4.00).

The word "Bellevue" has moved a long way from its original French meaning of "pretty scene." Bellevue is called many things now, but hardly ever a pretty scene. Here is one of the largest general hospitals in the world, willing to tackle anything in medicine, surgery or midwifery. Any twenty-four hour period at Bellevue is certain to be packed with tragedy and comedy, pathos and bathos, triumph and failure. Arthur Gelb, the well known drama critic, his wife (an experienced author) and Dr. Cutolo, the Deputy Superintendent at Bellevue, have combined to produce a book which recites the Bellevue story in a series of dramatic (sometimes melodramatic) anecdotes. While not pretending to give any solid data on medicine or hospital administration, the book will give the nonmedical reader a respect for the doctors, nurses, attendants and others who keep beating the heart of one of the most extraordinary organisms in the world: Bellevue Hospital. The pages are packed with all sorts of enchanting stories. Once you miss the page, though, you are out of luck. They forgot an index. Somewhere in the book must be the fascinating yarn about Nellie Bly. Without an index, I can't find it. But it's there. I think.

VICTOR HUBERMAN, M.D.

The Neuroses in Clinical Practice. Henry P. Laughlin, M.D. Pp. 802. Philadelphia 1956. Saunders. ($12.50)

Most of the patients who come to the general practitioner's office are neurotics—or, at least, a strong emotional component colors the illness. Naturally, therefore, many psychiatrists have tried to write handbooks for the family doctor. In 1945, Macmillan published Levine's *Psychotherapy in Medical Practice*. And six years later the Ronald Press gave us Colby's *Primer for Psychotherapists*. These slim volumes were compact, useful, and to the point. However, they devoted little space to the development of psychoneuroses, presumably because they wanted to keep down the size and cost of the book, or because the authors thought that the general practitioner was not really interested in dynamics.

Laughlin does not, in this fashion, talk down to his readers. Here is a large, solid volume in which most of the space is devoted to telling you how the neuroses develop. It is, for all that, an unpretentious volume. It is innocent of the esoteric jargon which often makes psychiatric language incomprehensible to mortals. As an appendix the author includes a handy glossary of psychiatric terms.

There is a chapter on the fatigue reactions — a syndrome usually ignored by psychiatrists because there clings to it the shreds of the now discredited concept of "Neurasthenia." The book has several unusual features. Compact tabulations show each problem at a glance. This is helpful to the non-psychiatrist. And to the psychiatrist it provides wonderful fodder for mental hygiene lectures.

The author shows how psychoneuroses are actually defensive reactions which help patient instead of destructive reactions which ruin him. This is a unique feature of Laughlin's book. Few texts for non-psychiatrists take the trouble to explain this, and as a result, most GP's see pyschoneurosis as a meaningless, harmful, absurdity. Other good features are the excellent and legible format with its profusion of handy side captions, and the brisk and brief case reports. The case reports are often only a few lines long, but they are pithy and punchy. Each case unravels what would otherwise be an incomprehensible bit of psychiatric mumbo-jumbo. Laughlin gives short shrift to electroshock. He begrudges its value as a life-saver in the depressions, even though he must know that many depressed patients cannot afford, or are inaccessible to psychotherapy. Apart from this crotchet, the book is doctrinally sound and makes pleasant as well as instructive reading.

HERBERT BOEHM, M.D.

The Merck Manual. Edited by Charles E. Lyght, M.D., with contributions from 100 others. Rahway, N. J., 1956. Ed. 9. Pp. 1888. Thumb-indexed edition $6.75. Deluxe edition $9.00. Published by Merck & Co., Inc.

The Merck Manual needs no introduction to physicians in this, the state of its publication. Although it runs to almost 2000 pages, it is printed on thin opaque paper so it is easy to read and easy to handle. Both the $6.75 and the $9.00 editions are thumb-indexed. The book is chock-full of tabulations, special procedures, prescriptions (1600 of these!), diagrams, and advice on emergencies. There is material on what the doctor's bag should contain, how to stain slides, and how to convert from one system of weights and measures to another. The book aims to consider almost every disease to which man is heir, from *accretio cordis* to zona. In each section is a brief account of diagnosis and treatment. To compress all this in so small a space, the editors had to be a bit doctrinaire. However, considering how ambitious the project is, they have done extremely well. Nowhere else will the doctor find so much packed into a single small volume. It would be dangerous to use this as an unimpeachable authority in medicine or to permit laymen to use it as a first-aid manual. But there is nothing quite like it for a fast reference source for the busy doctor. Many others have tried to imitate it, but nothing this reviewer has seen is quite as good as the original.

ULYSSES S. FRANK, M.D.

Educating Spastic Children. F. E. Schonell, Ph.D. New York, 1956. The Philosophical Library. Pp. 242. With 5 diagrams, 11 plates and cerebral palsy record form. ($6.00)

Children with cerebral palsy are human and are worth educating. Not more than 30 per cent are feebleminded. However, many people including doctors, and sometimes the parents, feel uncomfortable about being near them. The tendency is to forget them or to say that they are suitable for custodial care only. In this book, Dr. Schonell spells out how it was possible to set up and follow through on an educational curriculum for spastic children. The problem is developed subject by subject. This is a potentially valuable volume for physicians, educators, parents and for all who have at heart the welfare of these tragically handicapped children. Theoretical material in it is kept to a minimum. The author tells us how it actually was done at several special schools. And what was so gallantly done there can be done elsewhere.

RALPH N. SHAPIRO, M.D.

Clinical Examinations in Neurology. Edited by E. C. Clark, M.D., Lee M. Eaton, M.D. and J. G. Rushton, M.D. and written by neurologists of the Mayo Clinic. Pp. 370. Philadelphia 1956. Saunders. ($7.50)

In neurology as in few other branches of medicine, meticulous examination is the key to diagnosis. After 30 years of trial and error, the neurologists at the Mayo Clinic have worked out usable neurologic examination forms, and copies of the several forms are included in a pocket in the back cover of this book. While the chapter on mental function is somewhat stiff and amateurish, the rest of the book is briskly written and highly practical. It includes some very shrewd tips on history taking. Several subjects are taken up in commendable detail. Thus, there are compact little monographs on aphasia, on pain in general, on convulsions, on neuro-ophthalmology, on nystagmus and on headache. Each of these sections is a gem of interest and utility. The illustrations are vivid and really illustrate. There is a magnificent 80-page section on muscle function. Some of the material on language function is unique. There is practical information on electro-encephalography and an extraordinary chapter on biochemical and pharmacologic aids in neurologic diagnosis. While $7.50 may seem a high price for a 370 page book, this manual will really facilitate mastery of the technics of neurologic examination. It gives the "what for" as well as the "know how."

HARVEY BLUESTONE, M.D.

TUBERCULOSIS *Abstracts*

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXX January, 1957 No. 1

Importance of Chest X-Rays in Total Radiation Exposure

A Statement by James E. Perkins, M.D., Managing Director of National Tuberculosis Association.

The report of a survey by six committees of the National Academy of Sciences on radiation is of particular concern to tuberculosis workers and physicians because of the emphasis which has been put upon the chest x-ray.

The survey was made primarily to evaluate the effect on the population of the testing of nuclear weapons and an estimate of future radiation likely to occur from the extension of peaceful uses of atomic energy. The use of radiation in medical practice inevitably came into the discussion. The point was made that all radiation is harmful from a genetic point of view, inevitably producing a number of injuries to the reproductive cells, which in turn results in certain mutations. The effect is cumulative and such injury may not show up for generations in the future. If such radiation is not controlled carefully, the inevitable effect, it is said, will be an increase in the death rate, a decrease in the birth rate, and ultimate eradication of the human species.

From a long-range genetic standpoint, a small exposure to radiation of the general population is just as bad as a high degree of radiation of a relatively small group of people. The important thing is the radiation of the reproductive organs (ordinarily referred to as the gonads). The local radiation of a part of the body, remote from the gonadal region, such as dental x-ray, will result in a certain amount of radiation of the gonads themselves. The report states the average dental x-ray results in a direct exposure of the face of about 5 r (r="roentgen," a unit of radiation) and of this exposure, .005 r reach the gonads.

There is some radiation that one can do nothing about; namely, the radiation from radio-active minerals and cosmic rays from outer space. With this so-called background radiation in mind, the scientists suggest that, in addition, man-made radiation of the general population should be kept below a total of 10 r's from conception to age 30, so far as radiation of the gonads is concerned. Those in occupations which necessitate greater exposure than this should keep such exposure below 50 r's during the first 30 years of life, and not to exceed another 50 r's between the ages of 30 and 40. (Nine tenths of children are born to parents under 40 years of age. Radiation of persons beyond the child-bearing age is obviously less serious.)

From the standpoint of mass use of chest x-rays for screening to detect the presence of active tuberculosis, the 10 r maximum limit obviously must be used, rather than the 50 r limit. The scientists point out that even a 10 r general exposure from man-made sources over the first 30 years of life will exert a certain toll in terms of hereditary defects, but apparently it is felt that this exposure will not be serious and is not unreasonable.

One can assume then that one has in the bank at conception 10 r's of x-rays or gamma rays. The object is to try to spend as little of these 10 r's as possible, doing so only when the benefits clearly outweigh the possible genetic injury which may result. This balancing of the assets and debits of a given x-ray exposure is an extremely difficult and rather nebulous thing, but it does make it clear that any x-ray program that yields no important practical results (such as using x-ray to check on the fitting of shoes) should be stopped.

To assist in the evaluation of a chest x-ray pro-

gram, it is first necessary to know how much radiation of gonads results from a chest x-ray. It is evident that scientists do not feel that such exposure is entirely negligible.

A study at the Brookhaven National Laboratory shows the total dose received as a result of x-raying various anatomical structures under varying conditions. According to the Brookhaven figures the exposure incident to the conventional chest x-ray is 0.05 r. This is the *total* dosage received by the part being x-rayed. It is not the dosage received by the gonads through stray radiation and scattering inside the body. From the genetic point of view, the important thing is not the total dosage but how much reaches the gonads.

Dr. W. Edward Chamberlain, Professor of Radiology, Temple University Medical School, Philadelphia, presented certain data at the last meeting of the Sub-committee on Tuberculosis of the National Research Council concerning the amount and seriousness of gonadal radiation resulting from various chest x-ray procedures. Dr. Chamberlain's calculations are as follows:

Approximate Radiation Received by the Gonads From A Single:

1. Conventional chest film (14" x 17")	0.00025 r
2. Regular photofluorograph	0.005 r
3. Photofluorograph using the new mirror optic system	0.0015 r

On the basis of dosages given by the Brookhaven National Laboratory, the radiation reaching the gonads from a conventional chest x-ray or regular photofluorograph is apparently 1 200th of the total dosage received.

It is obvious from these figures that if the 10 r gonadal radiation were to be used up entirely by photofluorographs of the usual type, this would take some 2,000 such photofluorographic chest films during the first 30 years of life. Even if individuals followed the usual advice of an annual chest x-ray from the age of 15 onward, this would mean only 15 photofluorographs by age 30. Fifteen annual PF's would use up less than 1 per cent of 10 r's (actually .075 r) and would seem to make it clear that there is a large safety factor even in the use of the regular photofluorographs.

According to our data, the highest exposure chest x-ray gives no more gonadal radiation than the dental x-ray exposure. Fluoroscopy itself, of course, is quite another matter and gives a very high dose.

Conclusions:

From the above, certain tentative conclusions seem indicated.

1. Fluoroscopy should not be used for *screening* purposes. (It may be necessary, of course, for diagnostic purposes.)

2. Any x-ray program yielding data of no significance should be discontinued. (A given type of x-ray program may be justified in a certain population group and unjustified in another.)

3. In very few communities, if any, in the United States would routine chest x-ray screening of the general population *under the age of* 15 be justified.

4. From the genetic standpoint, chest x-rays of older people who have completed their families are of no importance, and furthermore, this is the group with the higher rates of prevalence of tuberculosis.

5. The standard 14" x 17" chest x-ray film gives such a low dosage of gonadal radiation it is essentially negligible at any age.

6. The use of the new photofluorograph camera using the mirror type of optics results in less than a third as much gonadal radiation as the regular photofluorograph.

7. Even the regular photofluorograph causes such a low dose of gonadal radiation that its use for tuberculosis screening purposes in individuals who have not completed their families is justified if these individuals are in population groups with a considerable prevalence of tuberculosis.

8. Determination of what groups should be continued to be screened by chest x-rays must be made locally upon the advice of the physicians guiding the program, such as the Trudeau Society or medical advisory committee.

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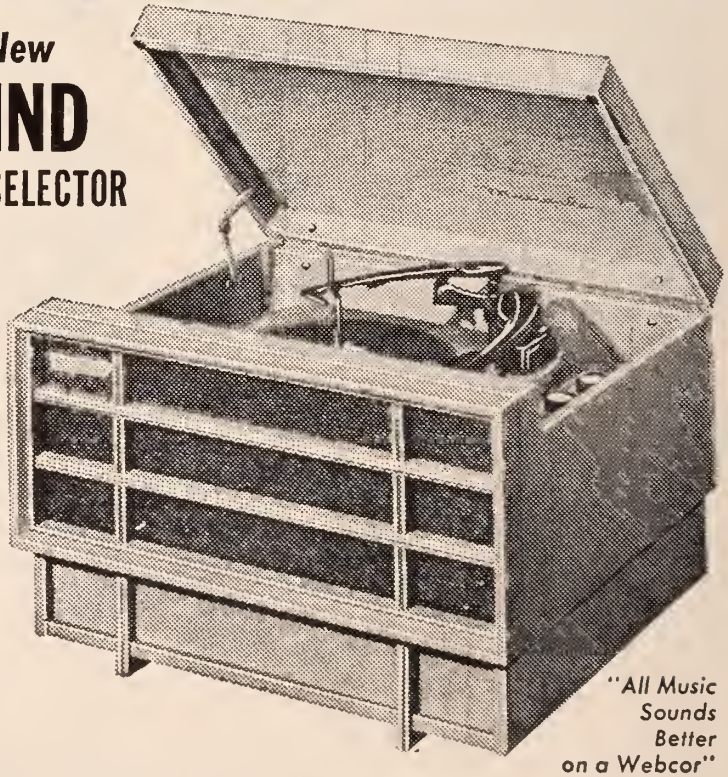
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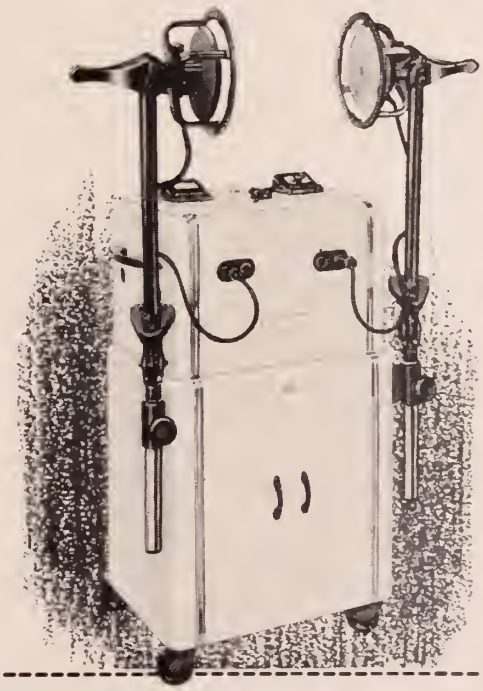
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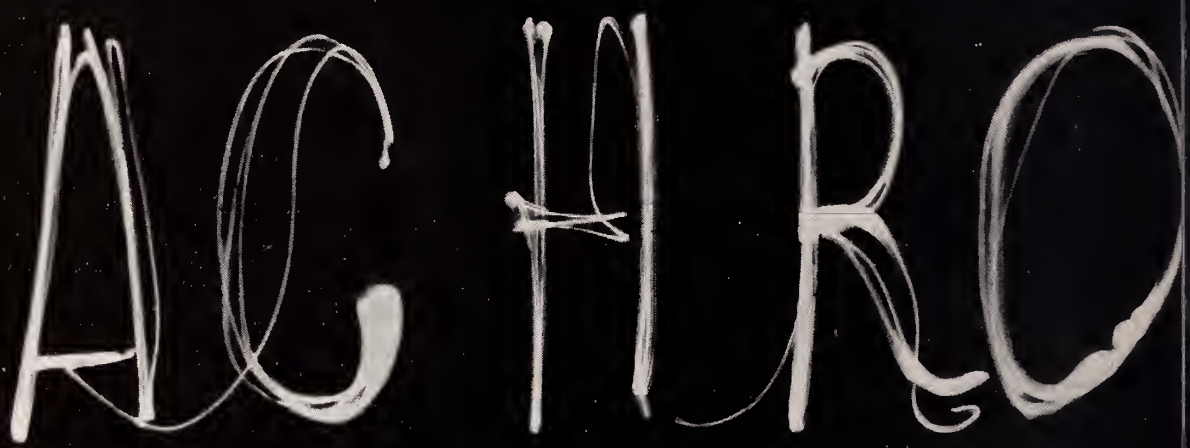
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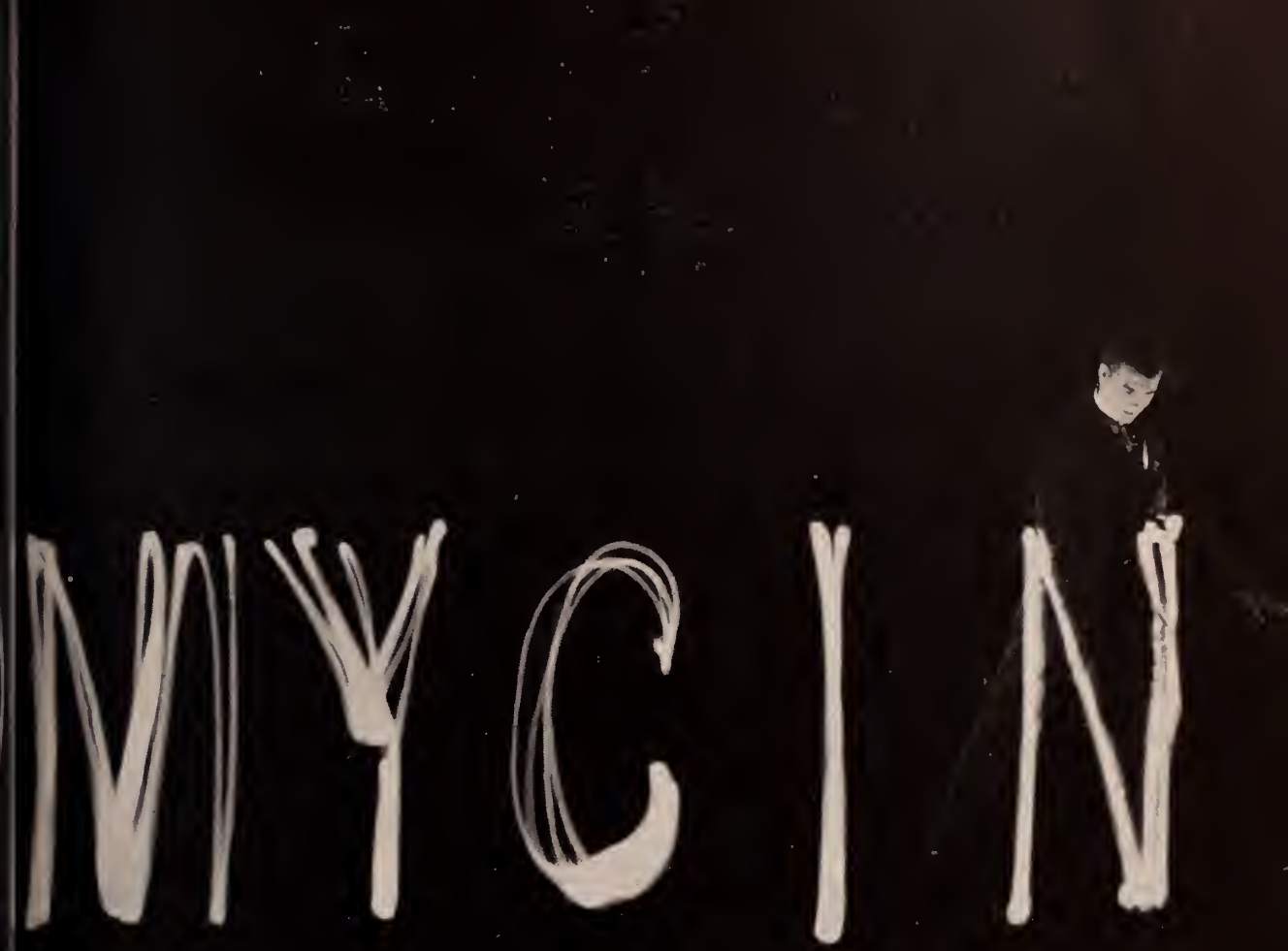
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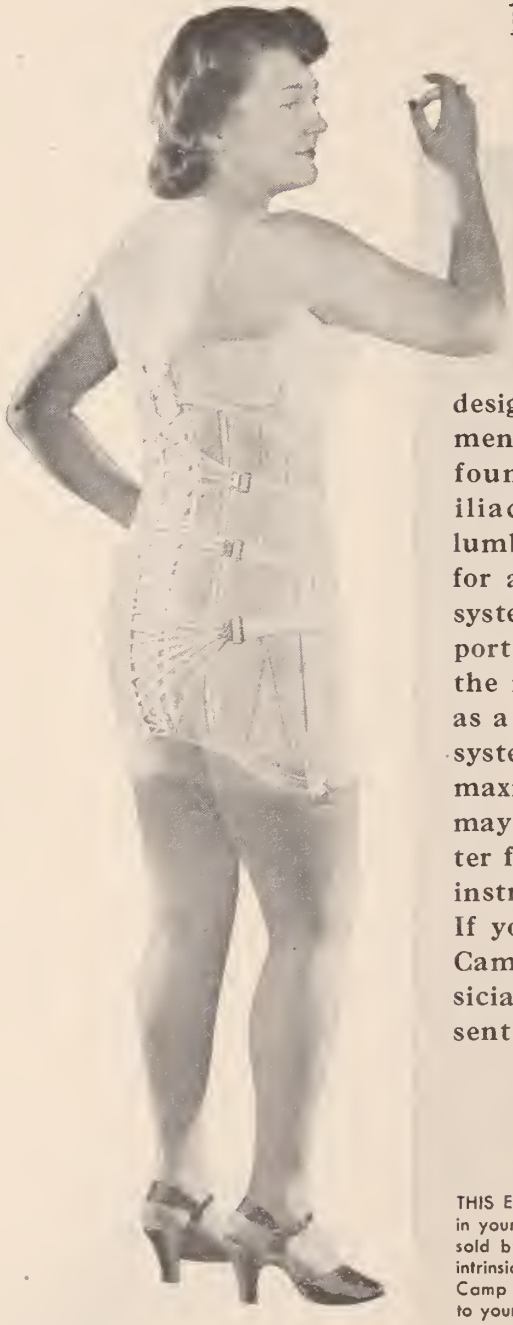
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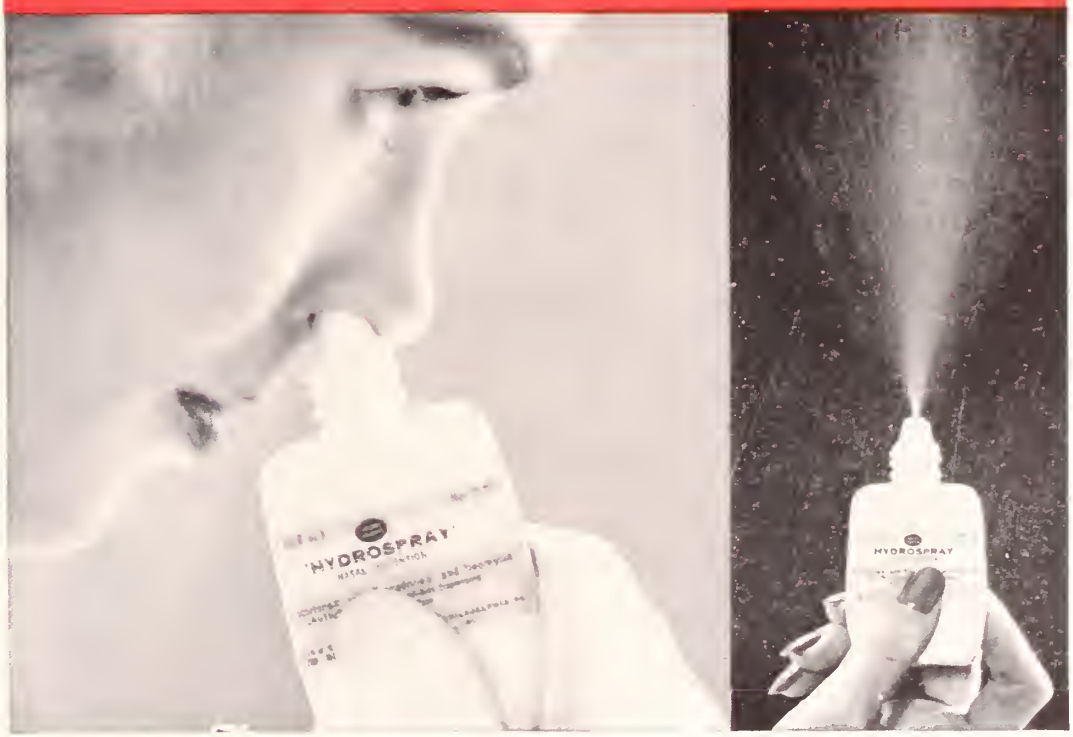
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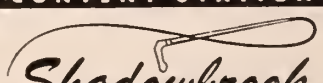
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The Use of Digitalis in the Treatment of Heart Failure in Myocardial Infarction	René Bine, Jr., M.D. San Francisco, California
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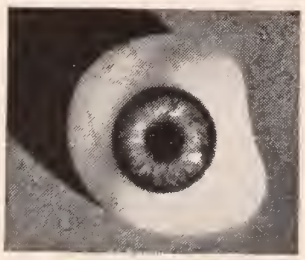
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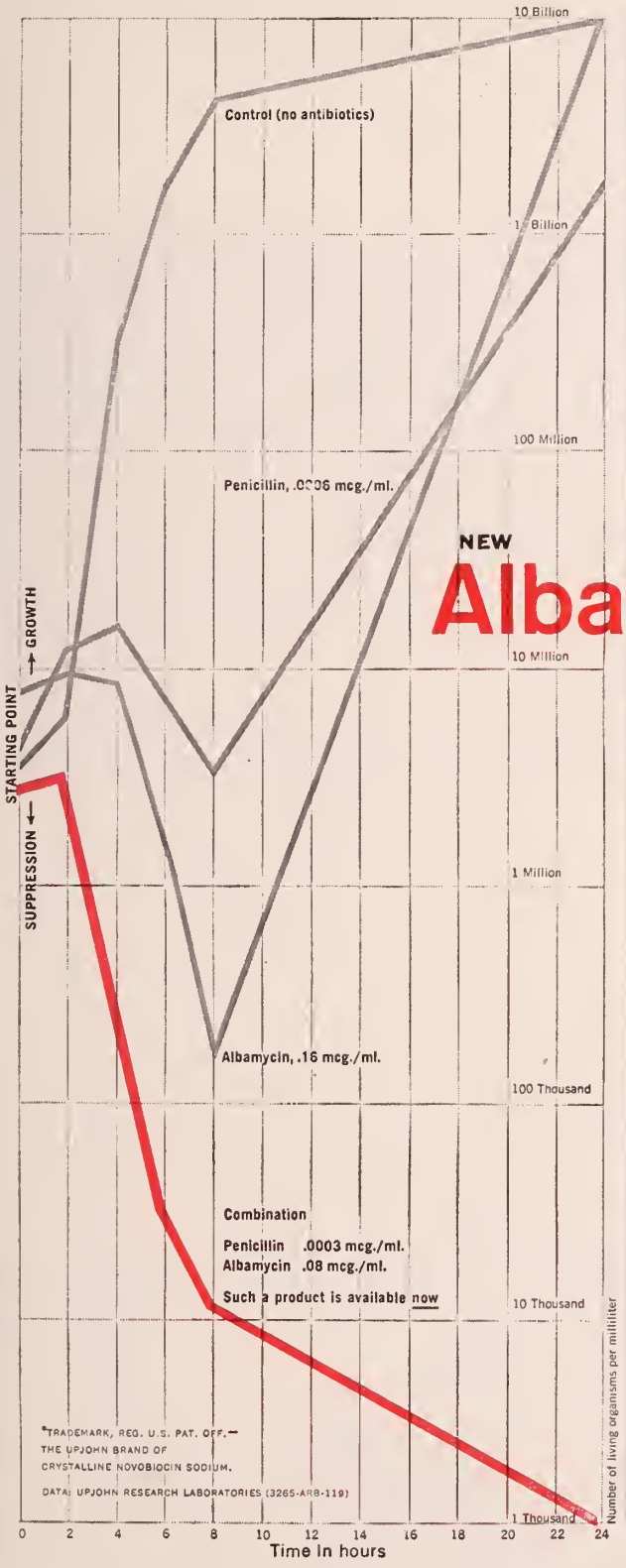
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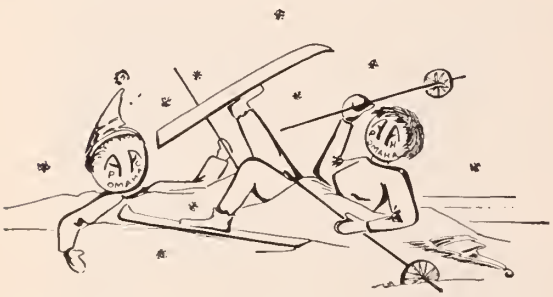
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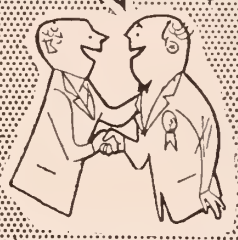
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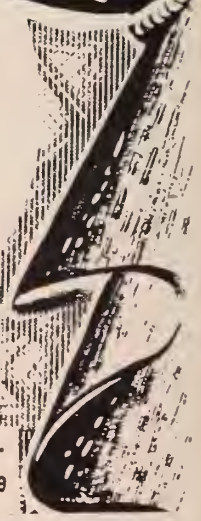
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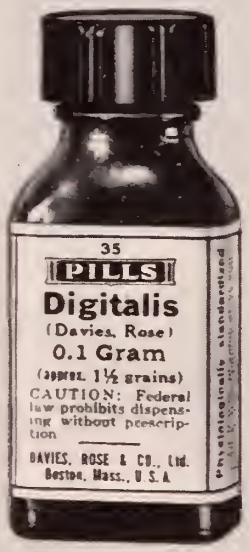
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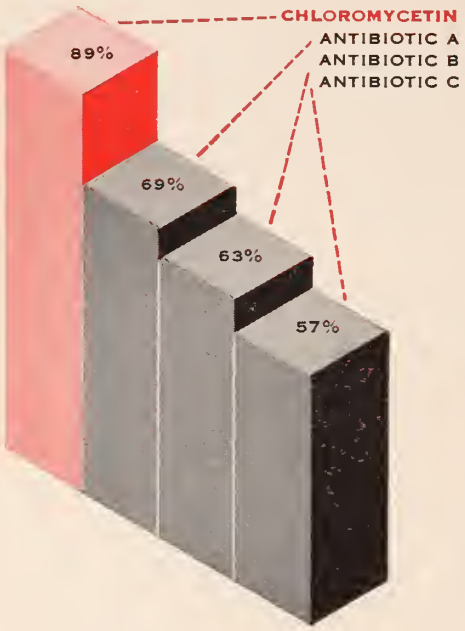
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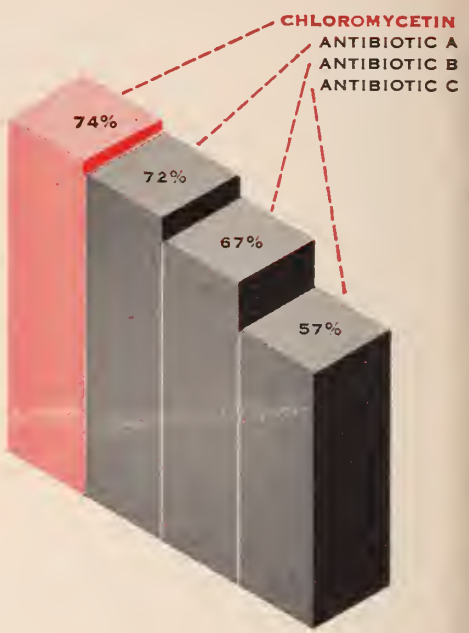
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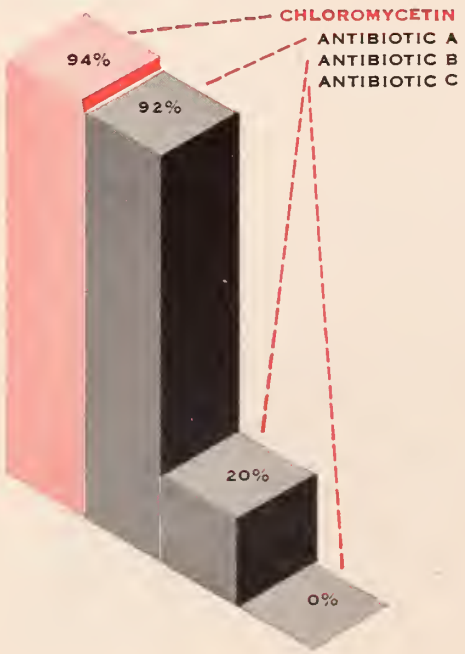
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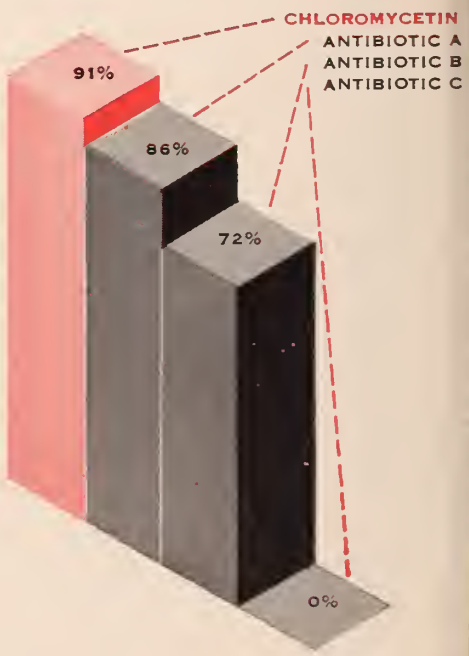
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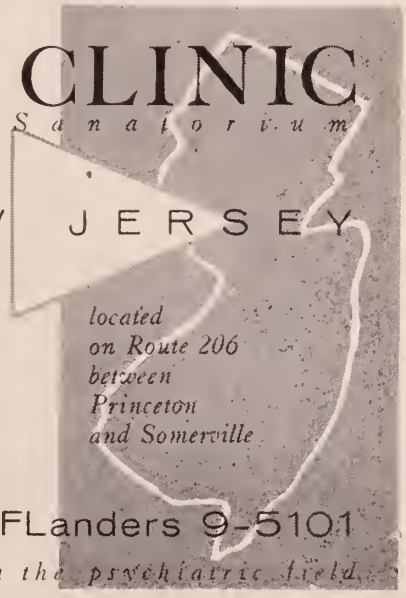
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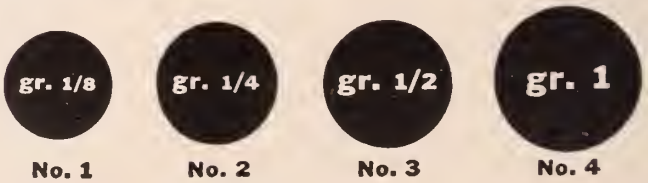
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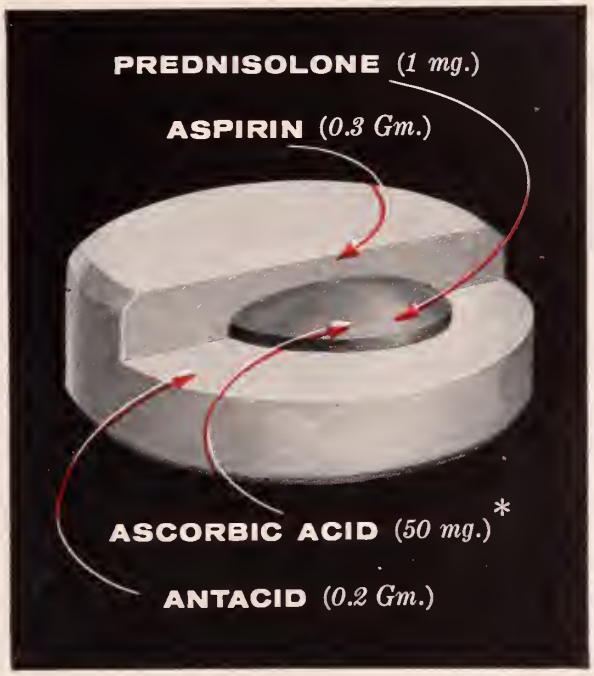
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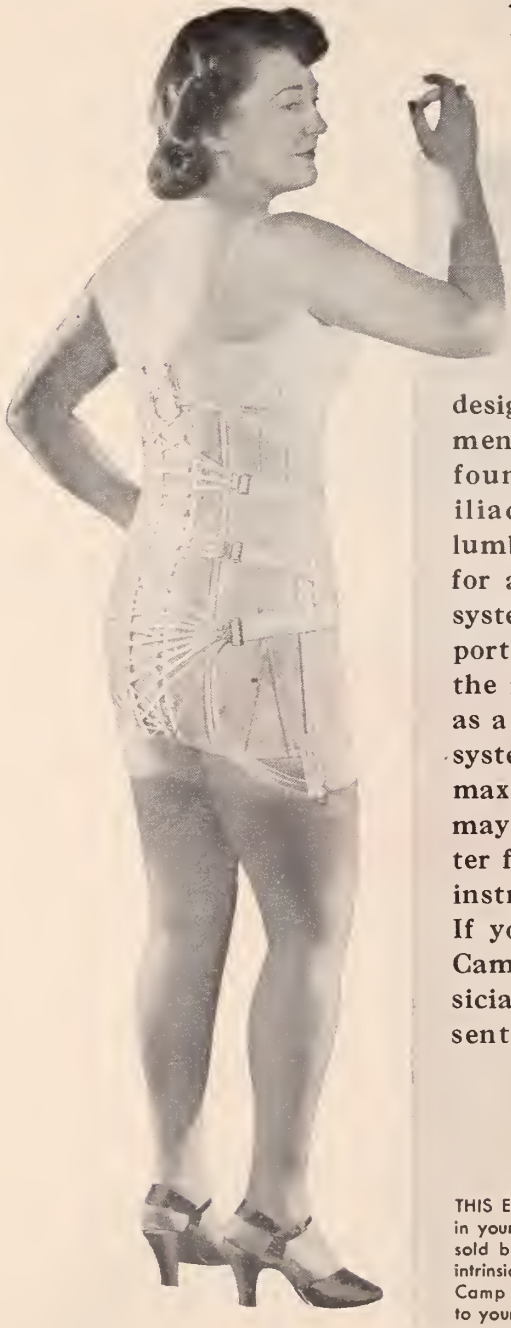
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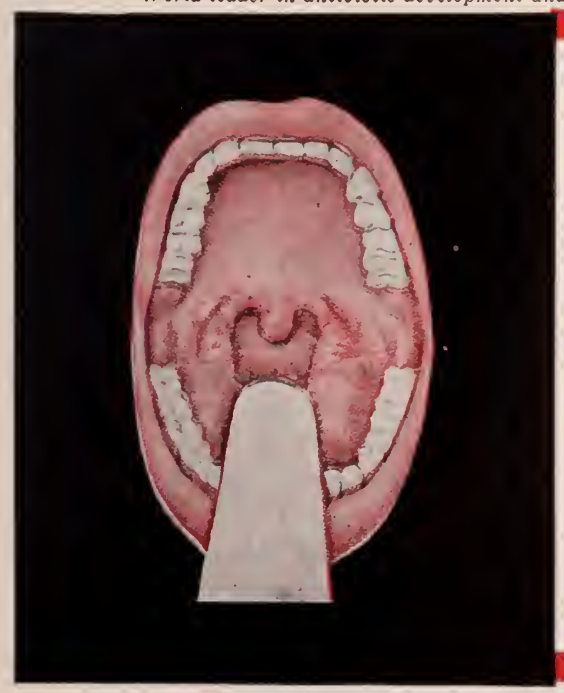
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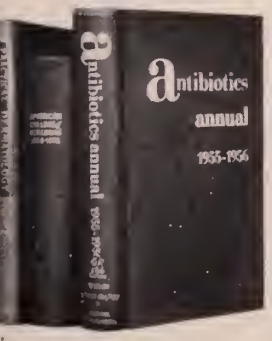
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1. Romansky, M.J., et al., Antibiotics Annual 1955-1956, p. 48,
2. Waddington, W. S., Maple, F. C., and Kirby, W. M. M., A.M.A. Archives of Internal Medicine, 1954, p. 556.

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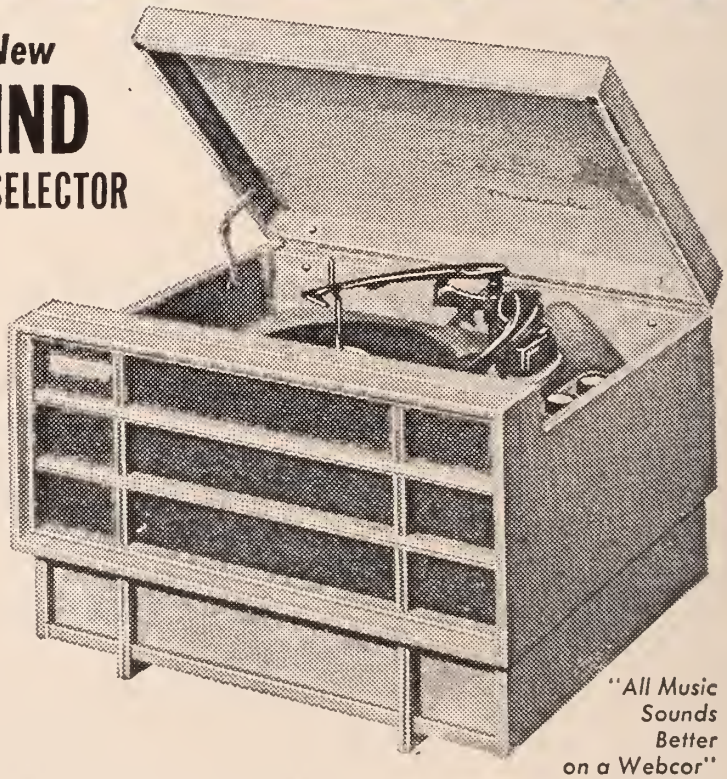
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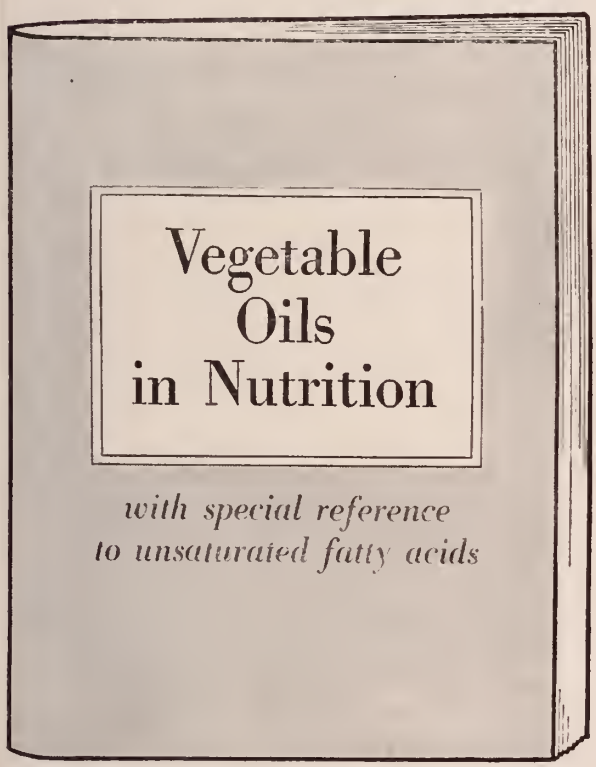
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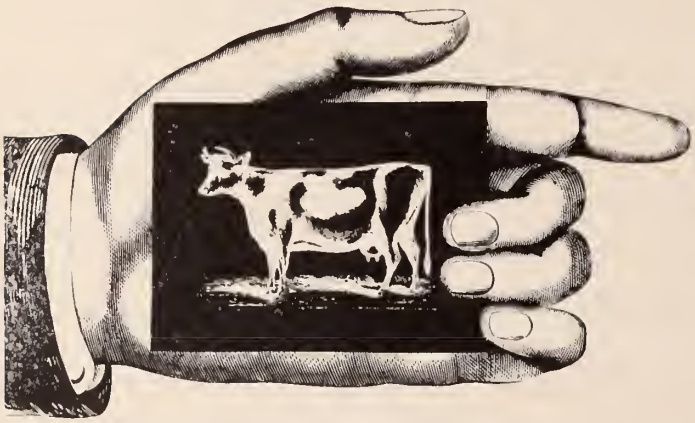
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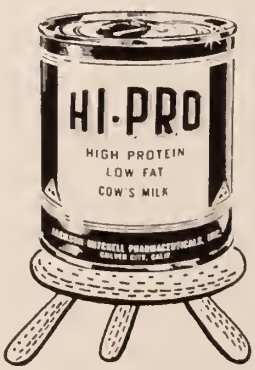
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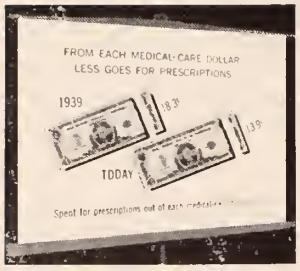
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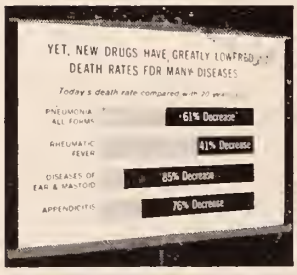
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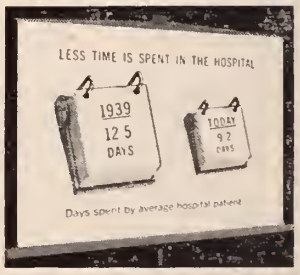
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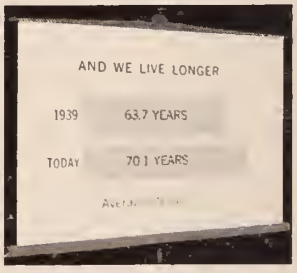








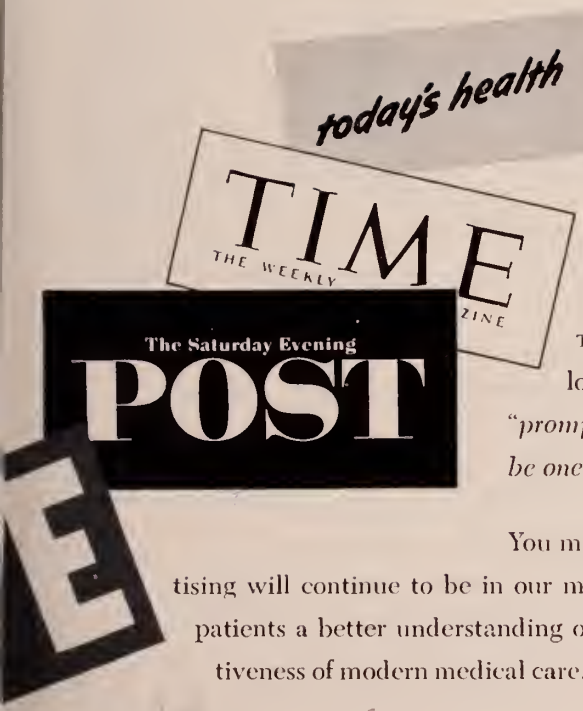
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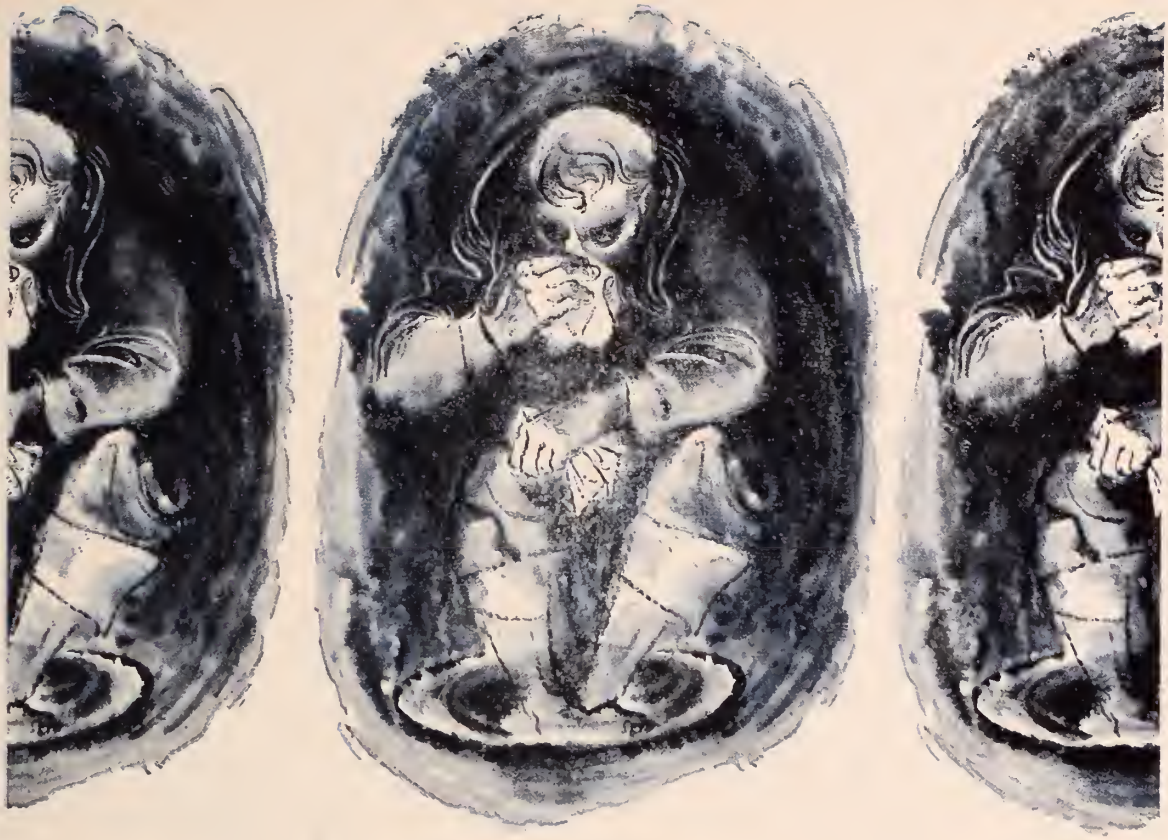
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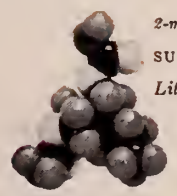
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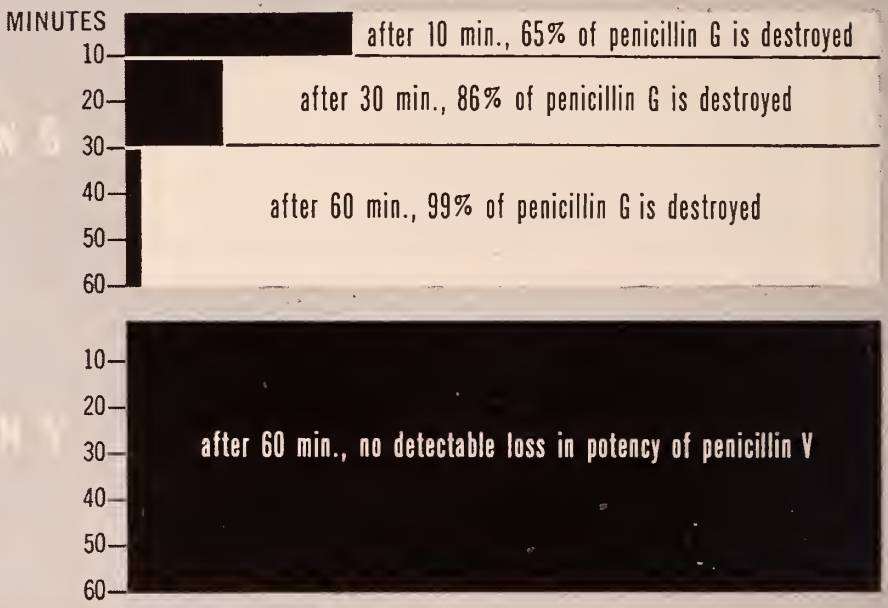
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Editorials • • •

Pharmacology and the New Beatitudes

Always we seek the one who can give us blessings. To some, the great blessing is serenity; to others it is excitement. Some want peace, some want thrills. Some want but to sleep, others want the energy to do everything except sleep. Some want life's pace to be speeded and others want it to slow down. Some want to eat heartily and enjoy every morsel; others prefer drinking but want to neutralize the hangover. Some want conscience and consciousness sharpened; others want them blunted. There are those who would gain weight and those who would lose it; those who want to be shorter and those who want to be taller.

So we look forever for the person, the force, or the spirit who can give us these blessings, each according to his own peculiar calculus of heaven and hell. We have sought these desiderata in the past from priests both high and low, from kings and emperors, from wits and wizards and witches, from magicians and from magis, from demagogues and demigods. We have sought for such blessings in the rites of nature and in the rites of the supernatural. We have sought them through prayer and through poetry. We have never attained them, for this is, it seems, like all promised lands, more promise than performance. It was, as the Hobo's Song puts it, "the big rock candy mountains where the jails are made of tin; and you can bust right out again, as soon as they put you in."

Now comes the modern purveyor of the promise, the one who will sell a ticket to Utopia—one way or round trip, as you wish. He is the pharmacologist. From his magic vat he will mix us a stimulant to give energy or virility, a sedative to soothe us; a magic carpet that will waft us to a dream world, and an anti-hallucinogen which will bring us back to earth; an appetizer so that we may eat heartily, combined with a metabolizer so that we will not gain weight. He will cook us a concoction that will make us feel pleasantly high and a swift-acting soberizer that will res-

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cue us from the DT's. He offers us tranquility when we want it and stimulation when we have had enough tranquility. Soon he will send the detail man to tell us of a slow-release capsule that will, for a week-end, give us in proper order the stimulant, the aphrodisiac, the sedative, the anti-hangover product, the tranquilizer, the hypnotic, and then the pep pill. The old magic vanishes to give way to the Keeper of the Benzene Ring, the late twentieth century Merlin who from his beaker, retort and cauldron will brew for us the best of the beatitudes. The Three Kings of Cologne yield to the creative chemist, the modern Melchior, Gaspar and Balthasar who promise to lay at our feet gifts beyond the dreams of the original Magi. And maybe they will do it, at that.

Compulsory Marriage Doctoring

Today there are about 60,000 divorced people in New Jersey. This does not include the number—estimated as close to 200,000—of persons in the deserted, spouse-absent, and informally-separated category. If you see a hundred children in a playground, chances are that 11 or 12 of them have separated or divorced parents. It is possible to argue that this is a healthy situation, though few would buy any stock in such a thesis. The argument would be something like this: in the old days when divorce was a scandal, people who had come to hate each other continued to live together in an explosive, tension-ridden state. Now they make a clean, maturely worked-out break, so the tensions are relieved.

In practice, however, the prodromal period, before that formal break, is usually one of poisonous hostility. There is nothing healthy about the high rate of marital breakdown.

In a quest for some solution, the New Jersey Supreme Court named a committee of distinguished persons—not one of whom was a physician—to study the matter. This committee recommends the establishment of compulsory reconciliation conference. Here, in brief, is their proposal:

—A lengthening to five days of the waiting period between the application for and the issuance of a marriage license, subject to the power of the court to grant exceptions;

—The issuance of a brochure relating to marriage counselling when application for a license is made;

—A uniform civil marriage ceremony ritual;

—Establishment by the State of a family counselling service;

—Establishment of a Conciliation Division of the Superior Court to have jurisdiction over conciliation and reconciliation conferences;

—Requirement that before filing divorce or separation action, the complaining party first file a "notice of intention";

—Directing mandatory reconciliation conferences except where excused by the Superior Court;

—Regulating the procedure for voluntary and involuntary conferences;

—Requiring the appearance of the defendant in every uncontested divorce, annulment or separate maintenance action.

The theory is this: when a rift develops between the couple, they need guidance. Let the State provide this guidance. If one spouse refuses to discuss his or her intimate problems before a strange counsellor, then we will use the power of the State to compel his appearance. In many cases, perhaps in most cases, such conferences will come too late. Still, even with a batting average of only 10 per cent, a lot of marriages could be salvaged this way.

Doctors will raise some questions about this program. First, one wonders about the "privilege" afforded communications between a spouse and a marriage counsellor. If the conference fails and a divorce is instituted, can the conciliator be subpenaed and compelled to testify what was told him in confidence? Under the present law, yes. However, the suggestion is that conversations between spouses and conciliators could be protected by the same privilege that now cloaks attorney-client contacts. Physician-patient communications, no matter how personal or confidential, would still be open to exposure in court, under threat of a jail sentence for the doctor who wants to fol-

low the ethical canon on the subject. The counsellor would be given an immunity denied to the licensed physician.

Some physicians have a superior understanding of marital breakdown. This is true of many family doctors who, as the designation suggests, are advisers to the entire family. It is true of many pediatricians, obstetricians, gynecologists and psychiatrists. But this program makes no place for the doctors, except as peripheral consultants. This is partly our own fault. The State cannot afford top-bracket executive salaries to its conciliators, nor can it pay $50-a-visit-fees for many consultants in such cases. And can we fairly ask physicians to sacrifice substantial private-practice time for the thankless task of serving as medical advisers to such a program at income-losing fees?

Physicians shudder at the word "compulsion," yet a purely voluntary system here would probably not work. Where one spouse will not attend a conference, the only alternative, the committee says, "is an assumption that the situation is hopeless." The committee is, very properly, unwilling to take so defeatist a position.

From scanning its literature, one gets the impression that the plan is based on the thesis that most marital difficulties are either economic or sexual. The corollary is that a patient counsellor can get the aggrieved party to blow off steam harmlessly. He would then encourage reciprocal tolerance, and throw in some practical advice on sexual or budgeting matters and thus the marriage is saved.

This would seem to by-pass the deep-seated personality conflicts that are at the root of many marital failures. If a husband projects on to his wife a deeply buried, primitive, guilt-laden hostility to his own mother, superficial counselling is not going to help much. Sexual dissatisfactions may lead to querulousness; but it is also true that feelings of hostility may lead to sexual inadequacy. It is a responsibility of our psychiatrists to provide enough experts to serve as consultants here. We cannot blame the non-medical counsellors if many conferences ignore the root of the trouble, when we doctors fail to furnish professional staffing for the agency.

The hope is expressed that many marriages could be salvaged after one or two conferences. The committee quotes Gelhorn's study* which shows an average number of visits per case to be 3, 4 or 5. Most psychiatrists would be shocked at the thesis that any significant personality reconstruction could be effected in 4 or 5 visits. To be sure, the proponents of the program say that they are not aiming at personality reconstruction. Yet something more than a drop of oil on troubled waters is needed to hold together a marriage that is falling apart. The lawyer's traditional faith in compulsion is reflected by the committee's approving citation of Gelhorn's conclusion* that "an *authoritative* exhortation from a wise and sympathetic judge may lead to a reappraisal of the possibilities of making the marriage work."

One could wish for more physician-participation in this ambitious project. As citizens and medical advisers we will all want to see the program work. It will offer the medical profession an exciting challenge. We will want to do our share.

*Gelhorn: *Children and Families in the Courts of New York City*, City of New York, 1954.

Nature's Loveliest Lottery

From the third month of pregnancy—maybe earlier—it will be possible to predict whether the uterine yielding will be a boy or a girl. That's what Sachs, Serr and Danon* promise us. They take some amniotic fluid and examine its cells to determine the chromosome distribution. They get this fluid by "abdominal puncture," a procedure that might make some obstetricians shudder. They say that their batting average is close to 100 per cent.

It *could* be—but whether it *should* be is another question. At first this sounds like

a wonderful idea. Almost as soon as the woman is sure that she *is* pregnant, the doctor will tell her whether to buy pink or blue linen for the layette. The cigars can be ordered in advance. The name can be chosen. The girls who give baby showers can tell the friends what kind of gifts to bring.

On second thought, we are not so sure that it is a good idea. Pregnancy, particularly the first two or three pregnancies, can be an exciting time for the father if not for the mother. Wondering about the baby's sex is half the fun. There is the constant reassurance that whether "it" is a boy or a girl we will want him (her) and love her (him). And when a boy is wanted and a girl is born, the reassurance surprisingly comes true. The pride of having a man-child is readily replaced with happiness at having a little girl. Sugar and spice and everything nice, that's what little girls are made of. And if a girl is wanted and a boy is delivered—well, anyone can take that in stride too.

And the fun of the double name, the "iffy" name. And the teasing question on the lips of all who love the couple, the question that bursts forth on D day. Girl or boy.

Everything seems to be blue-printed in this world of planning, forecasting, and poll-taking. Let them, if they wish, forecast next month's weather, or next week's stock market. Let them estimate the onion yield of Bermuda next year, and the number of veterans who will be hospitalized in 1985. Let them predict election returns and horse race results. But leave us, Dr. Sachs, Dr. Serr and Dr. Danon, leave us the fortuitous chance of our offspring's gender. Let us not have prognosis, planning and slick calculation at the wellspring of life itself. Boy or girl (may it definitely be one *or* the other!) we will love them both. If we are unsure of the outcome, so to speak, we will never be disappointed with it. Let us not make a sure thing out of Nature"s loveliest lottery.

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*Sachs, L., Serr, D. M. and Danon, M.: British Medical Journal, 2:795 (October 6, 1956).

Skin Deep

First Pygmalion sculped Galatea and gave her life. Then Shaw wrote a play on the idea, making the sculpturing cultural rather than mechanical. And finally Lerner and Loewe set it to music where, under the title of *My Fair Lady*, it keeps packing the house in Times Square. It is the eternal dream — the creation of life. It may be an actual life as in the original tale of Pygmalion. Or it may be the changing of life to something fuller and richer as in the Shaw version.

The dermatologists and plastic surgeons keep their noses on the mechanical grindstone. They create as Pygmalion did, by human sculpturing. In last December's *Archives of Dermatology*, for instance, Douglas Torre tells us that tools bought by sculptors to roughen clay are now being used by physicians to smooth away the scars of acne. The doctors buy these rasps not at a surgical supply store but at sculpture supply houses. They also use sandpaper and wire brushes. So, in this whimsical way, the story of Pygmalion and Galatea may be renewed in the office of the dermatologist (now a dermabrasionist) or in the operating room of the plastic surgeon.

And so we march on with the concept of the body as a machine, the doctor as a craftsman. One wonders, though about the ghost that operates the machine: the mind, the soul, the spirit, the emotional matrix in which that machine moves. We can plane away the scars or refashion the nose. But this is, in both senses of the word, a superficial operation. The true healer goes more than skin deep.

KENNETH E. GARDNER, M.D.

Bloomfield

The Orientation of a State-Wide Blood Banking Program*

Last November, The Medical Society sponsored a seminar on blood banking which was held at the Presbyterian Hospital in Newark. This is one of the papers delivered at that round-up of blood-banking information.

BLOOD banking today is assuming an increasingly important role in the health of every community. Blood is one of our essential life-saving commodities. It must frequently be available at a moment's notice and in adequate quantities. It must be collected, processed, stored, distributed and administered under proper supervision and laboratory controls.

The use of blood has multiplied many times in the past twenty-five years. Before World War II, the use of blood in large quantities as a civilian commodity was an exception rather than the rule. At that time the method for obtaining blood was to bring to the hospital a large number of persons and attempt to obtain from them one or more donors whose blood matched that of the patient. This was a time-consuming operation. When a rare type of blood was needed, it was either not obtainable or it was necessary to secure 50 to 100 donors to obtain a single pint of the rare type. The Rh factor was not even known. This cumbersome method was even worse when blood was urgently needed for a life-saving emergency.

The value of blood in the treatment of hemorrhage and shock has long been known to the medical profession, but not until World War II was its importance recognized by the public. Millions of pints of blood were used by the armed forces. The tremendous number of lives saved by this provided dramatic evidence of its great value. The use of blood today for civilian and peacetime purposes is widely accepted and far exceeds any idea of twenty-five years ago. Many operations are now performed on the heart, lungs, stomach and other vital organs which may require from 2 to 10 pints of blood for each operation. This was practically unheard of a generation ago. Today an adequate supply of blood for civilian use is an essential part of all good medical care programs.

Today, blood is used in the ratio of one pint for every 30 persons in New Jersey. Greater needs are anticipated. Before long, the ratio will probably be one pint for every 25 people in our state. New Jersey will soon have a population of 6 million. Thus, the number of pints of blood needed each year will soon reach 250,000.

The Essex County Blood Bank recently

*Read before The Medical Society's Blood Bank Seminar, Newark, N. J., November 2, 1956.

celebrated the donation of the 100,000th pint of blood. This amount has been collected over nine years and represents about 50 per cent of the blood used in Essex County. The Essex County Blood Bank is an example of how the first blood bank center in New Jersey was organized. It was the first blood bank in the state to be licensed by the National Institutes of Health.

THE Essex County Blood Bank is an unique organization which began as a three way cooperative project. It was originally sponsored and administered by the Essex County Medical Society under the direction of Dr. William D. Crecca, its first president. Blood is recruited by ten local Red Cross chapters and the project is financed from tax funds with the approval of the Essex County Board of Chosen Freeholders. This arrangement has continued since the beginning. Representatives from the local hospitals, management and labor now cooperate with the original three groups. Through hospital representatives a uniform basis for blood replacement on a one-for-one basis was negotiated. The management and labor representatives contribute their valuable support in the organization of industrial groups for the blood bank program. The Essex County Blood Bank operates on a "credit" basis. Blood is never sold. It is available to those groups and their families who have established "credit" in the bank. Any person who lives in or works in Essex County can establish credit through some group. Provision is made to lend blood in a life-saving emergency to local hospitals or to supply blood to friendless indigents.

With the increased use of blood for shock, hemorrhage, accidents, surgical operations, and to aid in recovery of many diseases, it has become apparent that there is a growing need for a uniform blood bank program for New Jersey. This need was first recognized by pathologists of our state, who are the physicians most closely associated with the technical problems involved in the blood bank program and its administration. This problem was first discussed by the New Jersey Society of Clinical Pathologists who then brought it to the attention of The Medical Society of New Jersey. Its importance was swiftly recognized. By the action of the Board of Trustees of the Medical Society, the Society of Clinical Pathologists was authorized to represent the Society and to study the problems on a statewide basis. It was also recognized that any state blood banking project should be an integral part of the Civilian Defense Program.

This body is now known as the New Jersey Blood Bank Commission. Dr. Sylvan Moolten is its chairman. Here are some of its recommendations:

1. That an adequate supply of blood of all types and Rh factors should be obtainable at all times for both routine and emergency use.

2. That a standard procedure similar to that of the National Institutes of Health be adopted by all blood banks operating in New Jersey, so that there can be uniform procedures for collection, processing, storage, distribution and administration of blood.

3. That recommendations be made for standard procedures in hospital laboratories, so that blood typing, Rh factors, cross-matching and allied procedures will be done on a uniform basis and will thus serve as a double check on all blood before it is administered to the patient.

4. That Blood Bank Centers be established throughout the state to collect, process, store and distribute blood to the hospitals and people of those areas. The Blood Bank Center would also serve as a registry of donors and as a clearing house for all types and quantities of blood available in that area, either in the Blood Bank Center or in local hospital blood banks. The Center would thus have a roster of the potential number of donors who would be available for emergency use, for any disaster or for civilian defense purposes and also an estimate of how many pints of blood could be drawn per hour with the facilities available in each area.

If an emergency arises in one area and the amount of blood required or types are not available, the Blood Bank Center can then communicate with another Center in an adjacent area so that blood can be quickly transferred from one area to another. This would be particularly valuable when rare types of blood are needed.

5. Since blood banking is a vital factor in the health of the people of New Jersey, it is the responsibility of (and should be under the sponsorship, supervision and administration of) the local county medical society.

6. Each Blood Bank Center should have its own facilities and administration. It may be necessary to locate the Center within a hospital building in some of the less densely populated areas. It should

not, however, be administered by the hospital in which it is housed.

7. An adequately functioning blood bank requires cooperation beyond the local medical society and the blood bank administrators. Since it is a vital community function, it is necessary to solicit the suport of the local industrial, fraternal, church, social and welfare groups to help operate and maintain the functions of the bank.

8. The proposed blood bank program is to be state-wide. It is the hope of the Commission that *all* blood banks in the state will eventually become licensed. This license may be one that requires legislation; or it could be controlled by the Commission on a permissive or optional basis. However, a license similar to that issued by the National Institutes of Health would be a primary prerequisite to maintain uniform standards for an integrated blood bank program with exchange privileges of actual blood between banks.

9. It is necessary constantly to inform the public of the value and need for an adequate supply of life-saving blood at all times for emergency and medical use; and also to instruct the technical personnel (both active and reserve) of the various blood banks in uniform and new blood bank procedures.

10. That uniform charges for blood (when it must be purchased) and uniform charges for hospital administration should be established. At the present time, all patients who have Blue Cross Hospitalization contracts are covered for those expenses which are incurred by the administration of blood within the hospital.

New uses and an increasing need for blood will continue. It is the hope of this Commission and of The Medical Society of New Jersey that an adequate supply of blood will always be available including adequate safeguards for its collection, processing, storage, distribution and administration.

45 Fremont Street

A Private Prison*

Since life itself will always impose restrictions upon us it is foolish to create needless limitations of our own. And yet through superstition, fear, and angry rationalizing, we voluntarily narrow our horizons, enclose ourselves in prisons of our own manufacture. When we create "districts" for people of other races, creeds, or colors, we shrug off the obvious fact that it is hard on them. So what? The answer is that we do a far more subtle damage to ourselves for it is we, as much as our victims, who are cheated out of the joys of a full and colorful life.

We suffer from the same kind of claustrophobia besetting those who are forever denied a magnificent view of a great city because they cannot bring themselves to go above the third floor.

When we find Catholics or Jews, Protestants or Negroes, French, Germans, or Chinese "peculiar"—when it's a case of "You can't deny it, they're just different from us, that's all"—we are on our way to a very small cell in our private small dark prison.

Whether all these groups are fundamentally different from one another I'm not sure. Different philosophies, different religious tenets guide the human race. But if a basic difference does exist, that is the fun. That is what should whet our curiosity, provoke us into wanting to know more about these people. Maybe we are more similar than we think; possibly not, but why put on blinders and plug up our ears instead of finding out?

Let's not erect high walls saying, "Here's me. Everybody else stays out." Solitary confinement isn't much fun.

We have enough built-in hurdles and obstacles to overcome as it is without shouldering huge outside prejudices. We have already curious limitations of the mind that are hard to master and that pretty well confine us anyway. I speak of the phobias and "allergies" that sway our behavior.

*By Ilka Chase. This is published in the interest of Brotherhood Week.

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Newark

Duplication of the Sigmoid Imitating Tuberculous Peritonitis*

Duplication of the sigmoid is a rare anomaly. To have one mimicking tuberculous peritonitis is still more unusual. The Martland Medical Center surgeons here report a unique case.

Duplications of the gastro-intestinal tract have many bizarre forms but generally produce a well known group of symptoms. The following case, however, seems so unusual because of its clinical and pathologic aspects that a case report is indicated.

The patient was a 7-year old well developed boy in no acute distress. He was admitted for tonsillectomy March 2, 1954. Before the operation abdominal distention was noted and the child complained of generalized abdominal pain made worse by eating.

He had previously been admitted on January 14, 1952, for pain in the right lower quadrant. At this time appendectomy was performed through a McBurney incision, without complete abdominal exploration. The pathologist's report was sub-acute appendicitis. Recovery was uneventful and the child was discharged on the seventh postoperative day. Six months later, he was again admitted for acute follicular tonsillitis. With penicillin, the tonsillitis subsided. It was noted that he felt weak and tired. Ingestion of food was followed by distention of the abdomen. Patch test for tuberculous peritonitis was negative. He was discharged from the hospital June 9, 1952. On November 5, 1952, he was readmitted because of repeated recurrences of pain in the right lower quadrant and loss of appetite. He was then a poorly developed, poorly nourished child and the abdomen was somewhat distended. Throughout the abdomen there was questionable shifting dullness and a fluid wave, and in the right lower quadrant at the site of a well-healed McBurney incision, there was exquisite tenderness. A smear for sickle cell anemia and a repeat patch test were negative. The roentgenologist's report on a flat film of the abdomen was: "Normal markings of the abdominal viscera are obscured by an overlying area of homogeneous opacity. Check for peritoneal irritation." The child was discharged November 12, 1952, with a diagnosis of ascites and anemia, and was not seen again until admitted for tonsillectomy March 2, 1954.

At this time there was only occasional vomiting. The abdomen showed generalized distention, flatness to percussion, a definite fluid wave, and questionable shifting dullness. Temperature was normal for the first ten days but rose to 102 on the tenth day, when the abdominal pain grew worse and the child vomited. Patch tests, both on admission and later, were negative. Roentgenogram of the chest and a pyelogram were negative. Flat film of the abdomen showed a homogeneous density like that noted in November, 1952, which was again considered to be due to ascites. Roentgenogram taken during the gastro-intestinal series (Fig. 1) showed the stomach pushed upward. Most of the small intestine was displaced into the left upper quadrant. There was obviously a large mass filling the lower portion of the abdominal cavity and pelvis.

In the light of three negative patch tests, the

*This work is from the Surgical Service of the Martland Medical Center. Dr. Hakim is Senior Surgical resident. Dr. Carter is Attending Surgeon and Dr. Schulte is chief of one of the surgical departments.



Figure 1. Roentgenogram showing stomach pushed upward and a portion of small intestine almost entirely displaced into left upper quadrant. Lower portion of abdominal cavity is filled with large mass.

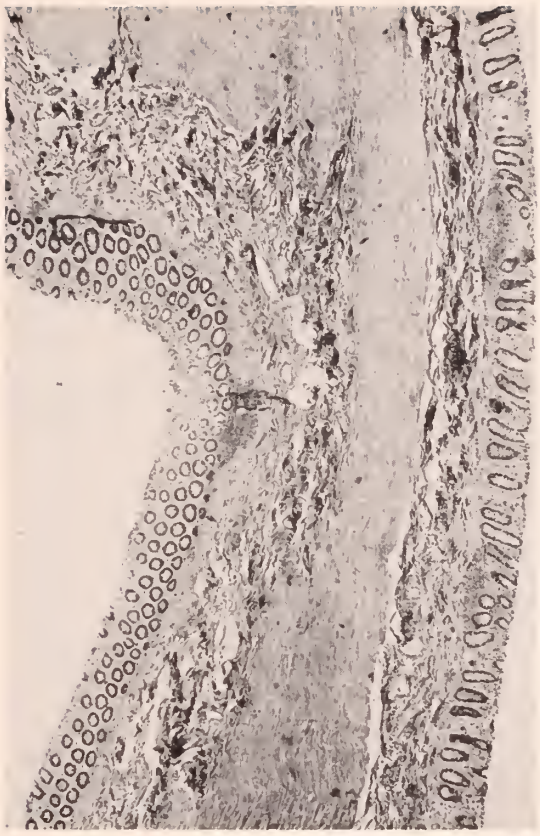


Figure 2. Microscopic section through cyst wall in area subjacent to sigmoid showed intact colonic type mucous membrane lining duplication.

diagnosis of tuberculous peritonitis was ruled out and a large mesenteric cyst was considered to be the most likely possibility. There was difficulty in explaining the acute abdominal tenderness and the temperature elevation in the presence of repeated low white cell counts. Emergency laparotomy was done on the fourteenth hospital day, March 16, 1954.

OPERATION

Under general anesthesia a lower right paramedian incision was made. A tremendous cyst filling the entire lower abdominal cavity was found. The incision was extended upward almost to the costal margin and downward to within an inch of the symphysis pubis. A massive dumbbell-shaped cyst was delivered through this long incision without difficulty. The sigmoid was stretched out over the isthmus connecting the two large lateral cystic masses. An attempt was made to dissect the sigmoid from the cyst. There appeared to be very little attachment of the sigmoid to the cyst wall. The lesion simulated a mesenteric cyst. It seemed inevitable that the blood supply of the sigmoid would be compromised if it were separated from the isthmus. Clamps were placed across the sigmoid above and below the point of attachment. The cyst, with 5 centimeters of sigmoid adherent to it, was resected *en masse*. The bowel was empty and there was no soiling of the peritoneal cavity. A two-layer interrupted silk end-to-end anastomosis was carried out. When the bowel ends were approximated, it was found that there was a defect of only about 2 centimeters in the mesentery.

The patient tolerated the procedure very nicely. Convalescence was uncomplicated. The child had completely recovered and was up and about on a full diet on the ninth postoperative day, and was discharged in good condition on March 24, 1954.

PATHOLOGIST'S REPORT

"This is a flaccid, thick-walled, dumbbell-shaped cyst weighing 1800 Grams. Over the isthmus of the cyst is stretched a resected portion of sigmoid. On opening the sigmoid no connection is noted between it and the cyst cavity. The cyst is intimately attached to the surface of the sigmoid. Within the cyst are 2 liters of turbid, dirty fluid with a faint fecal odor. The lining of the cyst

in many areas is covered with a thick, fibrinous exudate.

"Microscopic sections taken through the cyst wall reveal almost complete erosion of the lining mucous membrane with a fibrino-purulent exudate. The submucosa and muscularis are heavily infiltrated with leukocytes and eosinophiles. However, in the area subjacent to the sigmoid (Fig. 2) there is intact colonic type mucous membrane. In repeated sections from the cyst wall, no gastric mucosa can be identified. *Diagnosis*: Duplication of the sigmoid with inflammation."

While reports of various types of duplication are not infrequent,[1] this case in some ways seems unique. Distention of the abdomen with fluid, the temperature of 102, and the white cell count of 5,500 suggested tuberculous peritonitis. This diagnosis was invalidated by the patch tests. Roentgenograms then revealed displacement of the gastro-intestinal tract by an intra-abdominal mass. Of the 35 cases[2] of duplications of the intestinal tract reported by Pachman, none were distal to the cecum. In the 68 cases reported by Gross,[3] there were nine of duplication of the large bowel, four of which were long tubular duplications amenable to treatment by anastomosis of the two lumens distally. There were three retrorectal cysts. One case was a small sigmoid duplication treated by resection and anastomosis. One case of sigmoid duplication (measuring 12 by 10 by 8 centimeters) was found at autopsy. Neither of these presented a picture comparable to that seen in this case.

The embryology of these lesions is still controversial. They have been considered to be aberrations of Meckel's diverticula by many. Lewis and Thyng[4] have demonstrated diverticula in the ileocecal region of many animals, including pigs, rabbits, cats and sheep. However, this does not explain the location of duplications all along the gastro-intestinal tract from the base of the tongue to the rectum. Bremer's theory[5] of sequestration of epithelial masses during the recanalization of the gastro-intestinal tract following the solid phase is the more likely explanation.

Symptoms from reduplication of the gastro-intestinal tract[6] arise from (1) distention of the cyst with fluid produced by the lining mucous membrane, resulting in pain; (2) obstruction of the intestine adjacent to the cyst, a frequent outcome of which is the simulation by duplication of the duodenum of hypertrophic pyloric stenosis; (3) the presence of gastric mucosa in the mucous membrane lining the duplication, with resultant acid peptic erosion of the cyst wall followed by hemorrhage; (4) pressure on the mesenteric blood vessels exerted by duplications lying between the leaves of the mesentery, followed by interference with the blood supply of the cyst, inflammation and sloughing, a condition which appears to be the only explanation for the changes found in the cyst wall in the author's case, since there were no torsion, volvulus or connection with the bowel lumen; (5) those in the ileocecal region may form a leading point for intussusception.

The authors thank Mr. Harry L. Stevens for the histologic preparations and for the excellent illustrations.

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Daniel Santor, M.D.

Berlin

Treatment of Functional Gastric Distress With a Sustained Release Belladonna-Phenobarbital Combination

One of the general practitioners' commonest problems is the anxious patient with gastro-intestinal distress. Dr. Santor suggests that total treatment requires not only a sedative-anticholinergic drug but also a method of slow sustained release.

Patients with gastro-intestinal complaints frequently are tense, worried people whose physical discomfort may result from, or become complicated by emotional stress. In treating such patients, belladonna alkaloids are often used as supportive medication while the patient's insight into his emotional problems is being developed. Although belladonna is the most effective of all anticholinergic drugs, the extreme diversity of its pharmacologic effects often makes it impossible to confine its action to the structures at which therapy is directed. Thus, desired therapeutic responses can sometimes be obtained only at the price of disturbing side effects that may result in abandoning therapy in favor of less effective medications.

Recently, a new sustained-release preparation* became available which combines phenobarbital with belladonna alkaloids. Theoretically, this should be helpful in controlling functional gastro-intestinal distress because of its combined sedative and spasmolytic effects. Moreover, the sustained-release dosage form might reduce the incidence and severity of side effects if the slow, even release of medications in the gastro-intestinal tract eliminates excessive concentrations of drugs in the blood. The following study was undertaken to evaluate the efficacy of this medication.

MATERIAL AND METHOD

The study was conducted with 25 private patients (19 men, 6 women) who complained of symptoms that suggested a functional gastro-intestinal disorder. Gastric hyperacidity, "dyspepsia," pyrosis, "gas pains" and epigastric distress were among chief complaints. Most patients also exhibited tension and anxiety which caused or added to their physical distress. Three-fourths of the patients were in their forties or fifties.

The sustained-release capsule* contains the following ingredients:

(a)	belladonna alkaloids	
	atropine sulfate	0.06 mg.
	hypocyamine sulfate	0.31 mg.
	scopolamine hydrobromide	0.03 mg.
(b)	phenobarbital	1.00 grain

These medications are provided by means of small pellets of which about one third are

*Prydonnal® *Spansule* Capsules, Smith, Kline & French Laboratories, Phila., Pa.

uncoated and release an immediate initial dose. The others are coated with varying thicknesses of a digestible material, and gradually release minute doses of the medications over an 8 to 10 hour period. In addition to the sustained-release capsules, identical placebo capsules were used.

Of the 25 patients taking part in the study, 12 were being treated by me for the first time. These patients were given placebo capsules for two weeks before getting the active medication. Because the remaining 13 patients had been treated by me on several occasions, and their past responses to medication were well known they were not given placebos. None of these previously treated patients had ever received adequate relief of their symptoms from antispasmodic, antisecretory, or antacid preparations.

All patients were told to take one capsule in the morning and, if necessary, another in the evening.

During each visit patients were asked the following questions:

(1) Did the medication you have been taking for the past two weeks help to relieve your symptoms?
(2) Do you think that the present medication is better than, equal to, or inferior to previous medications you have taken?
(3) Did you notice any unusual effects while taking the medication? (Side effects were explained to the patients as dryness of the mouth, slightly blurred vision, and constipation or diarrhea.)

RESULTS

At the end of the first two weeks of treatment, four of the twelve patients who had received placebos reported slight relief of their symptoms. This is the average placebo response. The remaining eight patients had no relief. Since they had not been treated before, these patients were unable to compare the placebo with previous medication. Seven complained of mild headache, nausea, and constipation while taking the placebo. Patients were given active sustained-release capsules and were encouraged to continue treatment for another two weeks.

When seen again, 11 of the 12 new patients (91 per cent) had obtained beneficial results from the sustained-release preparation; only one patient was not helped by the medication. Asked if the medication proved more helpful during the second two weeks, 11 patients judged the active medication better than the placebo. One felt that the medications were equally ineffective. Many also mentioned that they did not feel as "nervous" while taking the second drug. Nine of the patients reported side effects, all mild, during the second two weeks of treatment.

Of the 13 patients who were known to have received little or no relief of their symptoms while taking conventional dosage forms of antispasmodic, antisecretory and antacid preparations, 12 (92 per cent) reported that the sustained-release preparation relieved their physical distress. Nine patients graded the preparation better than previous medications. Four thought that it was equal to other drugs they had taken. Only 4 of the 13 patients complained of side effects, mostly dryness of the mouth, while taking the sustained release preparation.

COMMENT

Better than 90 per cent favorable response was reported by two groups of patients who received a combination of belladonna and phenobarbital in sustained-release capsules* for functional gastro-intestinal distress. The fact that 12 of 13 patients previously refractory to antispasmodic, antisecretory, and antacid medication reported good results seems to substantiate the importance of using more than one drug to treat conditions that may be due to several causes. The sedative action of phenobarbital, by reducing tension and anxiety, seemed to be partly responsible for the excellent results obtained. The smooth, prolonged action of sustained-release medication also aided tense, worried patients by assuring them of ten to twelve symptom-free hours at a time.

Seven of the twelve patients who were given a placebo experienced side effects, all of which were described as being mild. While taking active medication, nine of the same patients complained of mild side effects. Although the sample tested was small, it would

appear that many of the side effects experienced by tense, anxious patients cannot be accurately attributed to the medication. Only four of the thirteen patients whose previous responses to medication were known reported side effects while receiving a combination of belladonna and phenobarbital in sustained-release form. None of the side effects experienced by patients required discontinuance of the sustained-release preparation.

These results seem to indicate that the sustained-release medication is not only an effective treatment for gastro-intestinal distress, but also that it may be sucessfully used in many patients who have proved refractory to conventional antispasmodic, antisecretory or antacid preparations.

SUMMARY

1. A sustained-release preparation containing phenobarbital and belladonna alkaloids* was administered to 25 patients with functional gastro-intestinal distress.

2. New patients received a placebo for two weeks and active sustained-release medication for two weeks. Four of the 12 receiving placebo-medication obtained slight relief of their physical distress; eleven of the 12 obtained complete relief while taking the active preparation. Twelve of the 13 patients who had been treated previously felt the active medication significantly relieved their symptoms.

3. Eleven of the 12 new patients found the sustained-release preparation better than the placebo; one felt it was as good. Nine of the 13 patients felt the sustained-release preparation was better than other medications.

4. Only 4 patients who had been treated previously experienced side effects during combined belladonna-phenobarbital sustained-release therapy. No patient experienced side effects severe enough to warrant discontinuing the medication.

15 West Taunton Street

Early Return to Work

Writing in the July 1956 issue of Industrial Medicine (25:307) Colonel Don Wenger says that we can return patients to work earlier with shorter post-surgical or post-traumatic convalescent periods—if we will but try. The Air Force reports only 7½ duty days lost following tonsillectomy. Average for a number of industries was 13¼ days. Following hernioplasty, a public health survey showed an average loss of 73 working days. In the Air Forces, the figure is 20 days from operation to duty.

Prolonged convalescence, says the Colonel, is no favor to the patient. "The appetite suffers, elimination is impaired, circulation slows, muscles waste, metabolism drops, and even the weight is reduced. Mentally the patient suffers from psychologic problems caused by separation from friends and normal activity, and from worry about himself. Actually healing of trauma is accelerated as a result of activity in some cases."

When feasible, the Air Force returns men to partial duty within six days following fractures. "Here is a significant gain in man-hours as a result of returning orthopedic cases to duty while they are still in casts."

Indirect evidence that early return to duty is not harmful is given by the lack of pulmonary embolus after surgery and from the incidence of recurrence of inguinal hernia. Following about 5,700 cases of surgery reported in 1953, "there were no reports of cases of pulmonary embolus." the physician added. "The incidence of recurrent hernias (27 out of 639 hernioplasties done) may also be an indication of rates of complications. Since this recurrence rate is less than 4.25 per cent it seems that disaster is not being courted by early ambulation and return to duty."

No marked difference was found in days lost by various age groups.

William H. Ainslie, M.D.

Donald T. Akey, M.D.

Metuchen

Meigs's Syndrome

An ovarian fibroma with fluid in the peritoneal and mediastinal cavities is the complex known as Meigs's syndrome. It is a benign condition, in the sense that removal of the fibroma effects a cure. To call it malignant would be a poignant error—especially if it led to the defeatist decision of "no surgery."

Though Meigs's syndrome is not rare, its occurrence is infrequent enough to warrant reporting a single case. It is also well to emphasize from time to time, the benign nature of the syndrome in distinction to malignant tumors of the ovary, breast, and organs which may present with ascites and hydrothorax. It was, indeed, the benign nature of the disease which prompted Dr. Joe Vincent Meigs[1] to call the condition to the attention of the profession in 1937. Yet one still sees and hears the syndrome erroneously applied to malignant tumors of the ovaries. The doctor should not consider the prognosis hopeless in any tumor of the ovary complicated by ascites and hydrothorax until he has histologic proof of malignancy. This will prevent the occasional patient with fibroma of the ovary from being considered inoperable and doomed to die when, in fact, she has an operable and curable lesion.

The presenting symptoms may be weakness, loss of weight, anorexia, dyspnea, cough, palpitation, pain in the chest or abdomen, and swelling of the abdomen.

The physical findings[2] must be hydrothorax, ascites, and fibroma of the ovary. After removal of the fibroma, the diagnosis is confirmed by disappearance of the effusions. The fibroma may involve one or both ovaries. The pleural effusion is on the right side in 75 per cent of cases and in 15 per cent it is bilateral. The mechanism of ascites and hydrothorax is unknown. Thoracentesis and abdominal paracentesis are of only temporary benefit. The fluid re-accumulates rapidly. However, this procedure provides material for cell block examination for ruling out malignancies.

CASE REPORT

A 33-year old housewife was admitted to Roosevelt Hospital, Metuchen, on May 21 for a right pleural effusion of undetermined cause. She had consulted her family physician for increasing cough and dyspnea of three months' duration. The cough was productive of small amounts of white thick mucus throughout the day. Constant dull pain was present in both shoulders, right chest, and abdomen. The patient stated she felt weak and "blacked out," one week previous to admission. Systemic review was essentially negative. Menses were normal as to interval and length of flow.

She was a well developed and nourished woman

1. Meigs, Joe Vincent, and Cass, John W.: American Journal of Obstetrics and Gynecology, 33:244 (February 1937)

2. Gould, E. A. and Kerr, H. H.: Annals of Surgery, 143:740 (June 1956)

in no acute distress. Positive findings were limited to the right thorax. There was decreased right expansion on inspiration compared to the left. Vocal and tactile fremitus was present. Breath sounds were absent. There was flatness to percussion from the second rib down, both anterior and posterior. Hemoglobin was normal, as were all blood and urine studies. X-rays showed a marked pleural effusion on the right. The left lung and pleural cavity were normal. Intravenous pyelogram was normal, as were barium enema and gastro-intestinal x-ray series.

Thoracentesis on the day of admission was productive of 2000 cubic centimeters of clear, straw-colored fluid. This was negative on culture and smear for acid-fast bacillus. Examination by the cell block technic was negative for malignant cells. The patient was placed on bed rest and antimicrobial drugs with a presumptive diagnosis of tuberculous pleuritis. By June 7, the fluid had reaccumulated in the right pleural space. Now 1300 cubic centimeters of straw-colored fluid were aspirated. Thoracentesis was repeated July 11 with 1600 cubic centimeters obtained. At this date abdominal swelling was noted. Shifting dullness and a fluid wave were elicited. A vague mass was palpated in the right lower abdominal quadrant.

Gynecologic consultation was requested, and one of us (W.H.A.) found a grapefruit-sized, hard, oval, freely movable tumor. Rectal examination was negative for masses in the cul-de-sac. Clinical impression was carcinoma of the right ovary with fibroma to be ruled out in view of the negative cytologic studies of the chest fluid and the mobility of the tumor.

Pre-operatively the right chest was aspirated of 2000 cubic centimeters of fluid. On July 19, the abdomen was explored through a right lower paramedian incision. Four liters of straw-colored fluid were aspirated from the abdominal cavity. There was a 1½ centimeter firm, oval plaque palpable on the supero-lateral aspect of the right lobe of the liver. Otherwise, the organs were normal except for an oval, firm, white 15 centimeter tumor replacing the right ovary. Its surface was smooth, glistening and intact though the contour was irregular. The tumor was removed and a left salpingo-oophorectomy, right salpingectomy and subtotal hysterectomy were done. Postoperative course was uneventful with the normal healing by primary intention. Pleural effusion and the ascites did not recur. The patient was discharged July 31, and remains asymptomatic to date.

The pathologist reported fibroma of the right ovary, and early fibromatous metaplasia of the cortex of the left ovary.

CONCLUSIONS

1. Meigs's syndrome is a benign condition.

2. Malignant tumors of the ovary with ascites and hydrothorax should not be included in this syndrome.

3. Laparotomy with removal of the fibroma confirms the diagnosis and effects a cure.

73 Amboy Avenue

133 Woodbridge Avenue

Postpartum Psychosis

Progesterone, the female sex hormone, should be considered for patients who show a severe increase of neurotic symptoms in the first week after delivery and puerperal cases of early psychosis in women, according to an editorial in the *British Medical Journal*.*

A study of 39 patients who had become psychotic during the first few weeks after delivery, showed that the relapse rate for those receiving progesterone with or without electric shock therapy was only 6 per cent. The relapse rate for cases not treated with the hormone was 44 per cent.

Thirty-four patients initially received shock therapy and psychotherapy. Seventeen improved and the improvement was maintained. Seventeen relapsed; one committed suicide. Of the remaining sixteen, five improved with further shock therapy. The remaining eleven of this group, together with five more patients, received progesterone alone or in combination with shock therapy. All these cases except one improved and one relapsed.

Progesterone was given in large doses, 100 mg. daily intramuscularly for about ten days and then orally in doses of 150 mg. After discharge the hormone was given by mouth for periods varying from weeks to many months.

*Post-partum Psychosis, British Medical Journal 2:89 (July 14) 1956

Paul deR. Kolisch, M.D.

Phillipsburg

Jaundice Following Transfusion*

Small hospitals are better than big ones in one respect at least—such would be the case if Dr. Kolisch's intriguing hypothesis is verified by larger studies. How could this hospital have had 600 transfusions without a single case of jaundice? Here's one explanation.

Reports are frequently made of jaundice following transfusions of whole blood. However, relatively little is said about the incidence of post-transfusion hepatitis. A series of 891 transfusions systematically investigated by Spurling,[1] *et al.*, revealed no case of post-transfusion hepatitis.

In the 14-month period ending in 1955 (September), 1206 transfusions of whole blood, in half-litre units, were given at the Warren Hospital in Phillipsburg, N. J. Questionnaires were sent to the physicians in charge of each case to determine the incidence of clinical jaundice in each recipient. Neefe[2] reports an incubation period of 32 to 111 days for post-transfusion hepatitis; therefore, this report is limited to individuals who have been followed for at least four months.

Replies were received covering 628 transfusions in 370 recipients.

One patient had had ten transfusions, one had had nine, and two had had 8 transfusions each. Seven transfusions were given to each of three patients. The number of transfusions received was as follows:

Number of Transfusions	Patients
7 or more	7
5	8
4	14
3	35
2	65
1	241

Twenty five patients had died before the end of this four-month period. One of these had had 8 transfusions; one had had 7; one had had 5; three of the patients had had three transfusions each. There were also 5 in this group who had had two transfusions each. In the other 14 fatal cases, the patients had received only one transfusion each. Ten patients were lost to the follow-up study, one of whom had had three transfusions and one of whom had had two. This leaves us with 335 recipients who had had a total of 562 transfusions followed for at least four months. Of these, one patient had been admitted with jaundice and had received one transfusion; no reaction was reported. No other patient who had received a transfusion developed icterus.

It is with trepidation that one reports almost 600 transfusions without any post-transfusion jaundice. Post-transfusion hepatitis *may* have occurred without jaundice, but if so, it could not have been very severe. Presumably with severe hepatitis, the reporting physicians would have had at least some readmitted for study. It is also possible that some recipients were immune as the result of previous hepatitis. It is most improbable, however, that only

*This work is from the Warren Hospital. Thanks are expressed to the medical staff of that hospital for their full, prompt and accurate reporting of cases under their care.

1. Spurling, N. *et al.*: British Medical Journal, 2:409 (Oct. 1946)
2. Neefe, John *et al.*: Journal of the American Medical Association, 154:1066 (March 27, 1954)

immunized recipients received infectious blood. There is, too, the likelihood that the reports from patients to physician were not entirely accurate. There is no evidence of inaccuracy in the direction of valetudinarianism,† however. This laboratory has had no requests for liver function studies in individuals in whom post-transfusion hepatitis was suspected. Finally, the reports from the physicians themselves, may be inaccurate. This could be attributed largely to indifference. The indifferent physician is more likely not to have reported at all. Indeed, it is the experience of many laboratory directors that any clinical difficulty that can be blamed on the laboratory is flung in our teeth without ceremony.

WHAT are the reasons for the low incidence of post-transfusion hepatitis in our survey? It is quite evident that the bulk of the medical literature originates in the large teaching center. This applies to transfusion studies as well. Usually these centers are in fairly large cities. The city is where the professional blood donor and the commercial blood bank thrive. There simply is not enough activity in the smaller community to warrant such enterprises.

The hospital in a less densely populated area is dependent upon its own blood bank or upon a regional bank for its blood supply. Warren Hospital operates its own blood bank. Donors are almost invariably non-professional volunteers who replace blood at the request of the recipient, his family or friends. There is no motive for such a donor to conceal any history of illness; indeed, if there is any motive at all, it is to falsify in the direction of ill health. Of course, the blood given in replacement is unlikely to be administered to the recipient for whom replacement is being made. But in a small town there is the strong possibility that the eventual recipient may be a friend or a relative of the donor.

In the larger city, on the other hand, one can easily sink back into the anonymity of the mass. The professional donor has an economic motivation to falsify his medical history in the direction of good health. The commercial bank has no way of discovering whether the donor has had hepatitis.

The regional blood center offers greater risk than does the small hospital bank. It must be centrally located in a city of at least medium size. If it does not accept blood from professional donors, it still operates in an area of increased population density and among greater numbers of people.

There is, to our knowledge, no correlation between the incidence of post-transfusion hepatitis and the origin of the blood transfused. My explanation is still only hypothetical. Perhaps subsequent studies in post-transfusion hepatitis will indicate the *source* of the blood used for transfusions in cases studied. In this way, such a hypothesis may be tested. If it is shown correct, remedial measures may readily be taken, and the incidence of post-transfusion hepatitis dramatically reduced.

845 Wilbur Avenue

†Valetudinarianism is a state of mind focussed on sickness or infirmity—Editor.

Harvey Bluestone, M.D.

Cedar Grove

Blood Pressure in Schizophrenia

America's number-one health problem is not arthritis, cancer, heart disease or the common cold. It is schizophrenia. Success in combating this malady depends on whether it turns out to be a metabolic or a psychogenic disorder. Although no statistical validation is offered, Dr. Bluestone's survey does suggest a metabolic factor and opens the door to further inquiry. The extraordinarily low incidence of hypertension in schizophrenics is certainly worthy of exploration.

Schizophrenia is economically, socially and industrially the most important chronic disease in the United States today. It requires more hospital beds, afflicts people in the prime of life and often lasts a lifetime. Its cost, both for patient care and in wasted lives, is vast but immeasurable. The nature of the malady is baffling. Three theories have been advanced to explain its pathogenesis. First, schizophrenia is a disturbance in interpersonal relationships. Second, it is an emotional maldevelopment within the individual personality. Third, it is a metabolic disorder.

This last formulation has received considerable impetus during recent years. The modification or eradication of schizophrenic symptoms by a hormone, insulin, and by drugs such as chlorpromazine would indicate a possible, though still unknown, physiologic abnormality. Schizophrenic symptoms have been induced by lysergic acid and mescaline. Many aspects of schizophrenic biologic responses have been reported by Cameron,[2] Hoskins [4] and others.

Investigation of the blood pressure of schizophrenics has been undertaken and is here reported to see whether it, like so many other processes, varies from that of the general population.

The blood pressures of 899 schizophrenics were studied. This represents all the cases now in the Essex County Overbrook Hospital in which a blood pressure was recorded on the admitting physical examination. Patients on whom this reading was made only at a later date, were not included. Treatment begins on admission to the hospital. Many methods including drugs, hydrotherapy, and the mere "being in the hospital" may have hypotensive effects and give false low results. The cases were not selected in any other way.

The breakdown of patients by age and sex is shown in Table 1. Current age at the time of last admission, and the blood pressure then recorded, are the figures used. Many of the patients, particularly in the older age groups, have had previous admissions. Few patients are below the age of 15 or over the age of 59 on admission. They have been eliminated because their number is too small to be of significance.

TABLE 1.

Age	Male	Female	Total
15-19	28	33	61
20-29	142	148	290
30-39	99	203	302
40-49	50	118	168
50-59	19	59	78
	338	561	899

Table 2 gives the breakdown by diagnosis. Those marked "undifferentiated" include chronic and acute undifferentiated schizophrenic reactions and cases diagnosed as "unclassified dementia precox" in the nomenclature used before 1952.

TABLE 2.

	Male	Female	Total
Catatonic	89	147	236
Undifferentiated	81	120	201
Paranoid	102	191	293
Hebephrenic	51	82	133
Simple	14	11	25
Schizo-affective	1	10	11
	338	561	899

Table 3 gives a comparison of the average blood pressure of schizophrenics with that of the general population. The non-psychotic averages are from an unselected series of 5,540 patients reported by Weatherby.[6] It will be noted that schizophrenic blood pressure is lower in both sexes in every age group. This confirms the results obtained by Freeman[3] in a careful study of 180 schizophrenics. It is considerably lower in women over 50, the group in which hypertension is usually most common.

TABLE 3A—MALE

	Systolic		Diastolic	
Age	Schizophrenic	Control	Schizophrenic	Control
15-19	113	116	69	73
20-29	117	120	73	77
30-39	122	123	75	80
40-49	124	127	76	82
50-59	133	137	81	85

TABLE 3B—FEMALE

	Systolic		Diastolic	
Age	Schizophrenic	Control	Schizophrenic	Control
15-19	144	118	74	75
20-29	115	120	73	77
30-39	122	126	76	80
40-49	131	139	78	86
50-59	135	153	81	90

More striking than the lower blood pressure averages is the small incidence of hypertension among schizophrenics. The standard used to determine hypertension was that described by Master[5] in 1952. He considers (as a result of a very extensive study) that 80 per cent of blood pressures fall in the normal range. Using his upper limit of normal as the boundary for hypertension, there would be a 10 per cent incidence of abnormal high pressures in the general population. Among the 899 schizophrenics there were 16 hypertensives, or less than 2 per cent. This means that the incidence of high blood pressure in schizophrenics is less than one-fifth that of the general population.

The few hypertensives by sex, age and diagnosis are given in Table 4.

TABLE 4.—MALE

Age	Type	Blood Pressure
18	C	170/85
24	U	160/100
26	C	178/104
27	C	170/120
29	U	156/80
33	H	180/70

TABLE 4.—FEMALE

Age	Type	Blood Pressure
23	C	160/90
25	P	162/100
26	U	160/100
32	C	170/100
36	C	154/100
37	U	154/84
46	P	172/108
48	P	190/110
48	P	206/104
49	C	200/90

In this table C=catatonic, H=hebephrenic, P=paranoid and U=undifferentiated.

Most hypertensives were diagnosed "catatonic," a psychosis in which motor symptoms predominate, or "undifferentiated" where the dominant feature is not clearly apparent. *There was only one case of hypertension among the 133 hebephrenics.* The accuracy of even this finding may be questioned. The patient weighed over 300 pounds on admission. Bardley and Eichna[1] have shown that blood pressures of obese individuals taken with the standard 13

centimeter cuff are much higher than when taken with a wider cuff. *Not a single schizoaffective or simple schizophrenic had hypertension.* The highest blood pressure, 206/104, was in a paranoid schizophrenic suffering from hyperthyroidism. Her basal metabolic rate taken a few days after admission was plus 45. Most of the cases of hypertension were mild (see Table 4).

There are two possible interpretations of the low incidence of hypertension among schizophrenics. First, schizophrenia is a disease in which the organism exists at a different biologic level. The changes in blood pressure are part of a composite picture of altered metabolism. Second, essential hypertension is a disease due in part to the stresses and strains of the outer world and the inner tension of the individual. The schizophrenic lives within himself. He responds to inner rather than external stimuli. In this way he is protected from a major cause of hypertension and consequently of hypertension itself.

SUMMARY

BLOOD pressures of 899 schizophrenics were studied. Average blood pressure of schizophrenics was found to be lower than that of the general population. The incidence of hypertension among schizophrenics is extremely low. Some implications of these facts are discussed.

Essex County Overbrook Hospital

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Atomic Hypophysectomy

Dr. Tobias* discusses the character of radiation. X-rays, even at 200 kilovolts, deliver much of the dose to skin owing to scatter. There is less scatter of the x-rays at 25 with the Betatron. At 190, deutron radiation (nuclei of "heavy hydrogen") has relatively little superficial effect and a sudden rise in dosage in the depth of the tissue. Protons (hydrogen nuclei), at 340 penetrate to greater depth, do not scatter, and do not diminish in intensity.

Pituitary irradiation with protons and deutrons has resulted in physiologic hypophysectomy in animals. Skin changes have been minimal. In one case, the progress of advanced mammary cancer has been halted.

Physiologic hypophysectomy, without undue effect upon the brain and surrounding structures has been achieved in humans, in advanced cases of breast carcinoma, upon whom all other available therapy had previously been used. At the time of the report, it was still too early to evaluate the effect of this treatment upon the tumor. Pituitary hormones may be essential to growth in 40 to 50 percent of breast carcinoma.

*Tobias, Cornelius, at the Congressional Hearing on peace-time use of atomic energy, Washington, D.C. Oct. 11, 1956.

Miles E. Drake, M.D., Ph.D.

Vineland

Antibiotics and Chemotherapy in Treatment of Respiratory Infections

When to use antibiotics and chemotherapy in children with nasopharyngitis? Dr. Drake's study suggests that the leucocyte count might be a good guide-line. If the initial count is over 10,000, these agents will reduce the incidence of complications. Curiously, if the initial leucocyte count was below 10,000, more complications occurred in children treated with antibiotics than in those treated with aspirin.

Those of us who can remember the pre-chemotherapeutic or pre-antibiotic days are not impressed with the assertion that these drugs are specific for *uncomplicated* upper respiratory infection in infants and children. This does not imply that with the development of a bacterial complication, these drugs are not beneficial. Indeed, they are often specific. But there is, too frequently, an indiscriminate use of these potent drugs. This may constitute a danger to the patient.

Loosli[1] believes that one cannot predict the course of an upper respiratory infection at its inception and that symptomatic treatment is best. Specific chemotherapeutic agents and antibiotics should be reserved for complications or bacterial invasion.

Cronk and his associates[2] were unable to confirm McLane's statements[3] as to the beneficial effects of penicillin in nonspecific upper respiratory infections. In fact Cronk *et al.* were unable to demonstrate any difference between a control and a penicillin-treated group of university students.

Hoagland[4] studied 309 patients with uncomplicated upper respiratory infections. He gave Aureomycin® to 154 of them without any difference or improvement in the course of their disease.

Jones and associates[5] studied 150 patients with a nonbacterial influenza-like syndrome. Treatment consisted of either aspirin, oxytetracycline or erythromycin. *The antibiotics had no effect upon the course of the disease* and there was no evidence of secondary bacterial infection in any of the patients. In fact the aspirin treated group was afebrile and symptomatically improved sooner than the patients who had received the antibiotics. Finland[6] and Karelitz[7] have shown that neither

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the sulfonamides or antibiotics (penicillin, Aureomycin®, Terramycin® or Chloromycetin®) are effective in the treatment of the common cold or common virus diseases. Since this work was completed, Hardy and Traisman [8] have shown that an initial white blood cell count of 10,000 or greater is an excellent guide for the administration of antibiotics to prevent bacterial complications. Furthermore they have demonstrated that antibiotics may be an important factor in complications in simple nasopharyngitis if the initial white blood cell count is below 10,000.

Obviously, there are differences of opinion as to the efficacy of the chemotherapeutic agents and antibiotics in the uncomplicated upper respiratory infection. To help resolve this problem, the following study on patients in a general pediatric practice was begun and has been carried on for 3¼ years. The study included 351 children who were seen from August, 1952, through December, 1955. Each child had or had had a temperature of 101 rectally or higher for 8 to 12 hours and presented physical findings referable only to an acute nasopharyngitis. Two major groups were studied. One consisted of private patients seen in the office. The other was a hospitalized group of service and private patients.

PRIVATE PATIENT GROUP

THE private patient group of 301 patients was given symptomatic care for fever. This consisted of aspirin for temperature over 101 rectal, sponge bath for temperature over 104 rectal and increased oral fluid intake. Each child or infant had a complete blood count, urine analysis and a nasopharyngeal culture on which antibiotic sensitivity was determined. Chest roentgenograms were taken on about 25 per cent of children or infants with a rectal temperature of 104 or more. They were seen daily while in the acute phase and at weekly intervals for 3 weeks after discharge. In addition, 41 of the patients had nasopharyngeal cultures two weeks after discharge. The following were considered as complications if they occurred within a two week period following discharge: otitis media, cervical adenitis, pneumonitis, tonsillitis, bronchitis, laryngotracheo-bronchitis, stomatitis, persistent cough and fever, rhinitis and diarrhea.

These 301 children were divided into five groups. Group 1 received bed rest, fluids and light diet as did all other groups, plus a lactose tablet. Group 2 was given aspirin every four hours in dosage for age group with one dram of elixir of Pyribenzamine®. Group 3 received Pediatric Gantrisin® suspension every four hours and Group 5 received syrup of Aureomycin® every four hours. All medication was continued for 48 hours after temperature was normal.

This group of 160 males and 141 females of all ages up to 12 years was carried on throughout all seasons for the last 3¼ years. Tables IA and IB give group and seasonal incidence with respect to complications. There was no statistically meaningful difference in the incidence of complications, except in the Aureomycin® treated group.

TABLE IA. COMPLICATIONS IN OUTPATIENT GROUP

Total Cases	Group	Complications (Per Cent)
62	1. Control	14%
65	2. Aspirin and Pyribenzamine®	16%
58	3. Gantrisin®	15%
57	4. Oral Penicillin	15%
59	5. Oral Aureomycin®	20%

TABLE IB. COMPLICATIONS AND SEASONAL INCIDENCE

Complications Ratio of	Fall	Winter	Spring	Summer
1. Control Group	16%	21%	15%	0
2. Aspirin and Pyribenzamine®	16	21	10	0
3. Gantrisin®	15	22	10	0
4. Oral Penicillin	14	17	15	0
5. Oral Aureomycin®	26	25	18	8

A leucocyte count of 10,000 was used as the frontier between a normal and an elevated white count. By this criterion three quarters of the initial white blood cell counts were be-

8. Hardy, M. and Traisman, H. S.: Journal of Pediatrics, 48:146 (1956)

low 10,000 in all children studied. In the control and aspirin-treated patients with complications, the initial white blood cell count was over 10,000 in 89 per cent of the cases. In the treated group with complications the initial white blood count was over 10,000 in only 17 per cent. This marked reversal was observed during the entire study and was difficult to explain in view of the fact that the total number of complications, irrespective of white blood cell count was statistically the same in the treated group (14 per cent) and untreated and aspirin groups (13.6 per cent). It would appear at the moment that the only plausible explanation lies in the fact that the antibiotic or Gantrisin® therapy eliminated the potential bacterial complications before the end of the observation period in the children with an elevated white cell count but increased the incidence of viral sequelae in patients with normal white cell counts. Credence is given to this hypothesis by a review of the complications. In the control series the complications could be predominantly bacterial, while in the treated patients many of the complications were thought to be viral in origin. Additional support is afforded by the longer recovery time in the treated as compared to the control group (Table II). The blood counts were under 10,000 in all treated complicated cases with differential count showing 70 per cent or more lymphocytes.

TABLE II. RECOVERY RATE AND DURATION OF ILLNESS

	Total No.	Complications (Per Cent)	Recovery Period Without Complications (Days)	Recovery Period With Complications (Days)
1. Control	62	13(8)	4.8	10.1
2. Aspirin & Elixir Pyribenzamine®	65	15(10)	5.0	9.2
3. Gantrisin®	58	12(7)	8.4	15.
4. Penicillin	57	14(8)	8.0	8.2
5. Aureomycin®	59	15(9)	8.6	15.8

In retrospect, due to these observations it would appear best to institute specific therapy to children only when the white cell count becomes elevated and give palliative treatment to all others until bacterial complication is evident. This certainly entails additional expense to the patient in that one or more complete blood count must be done. This may be offset by shorter recovery time and less expensive therapy.

The temperature elevations over 104 were: 35 per cent in the control; 34 per cent in group 2; 33 per cent in group 3; 20 per cent in group 4; and 33 per cent in group 5.

HOSPITAL GROUP

This had but 61 patients and represented only a small group under each treatment. However, these were rigidly controlled groups. The groupings were the same as in the private outpatients, except more frequent blood counts, chest x-rays and nasopharyngeal culture with antibiotic sensitivities were obtained. Table III shows the complication and recovery rate.

TABLE III. HOSPITALIZED GROUP

Group	No.	Complication Rate No.	Complication Rate Per Cent	Recovery Time Days
1. Control	13	0	0	5
2. Aspirin & Elixir Pyribenzamine®	12	0	0	7
3. Gantrisin®	12	0	0	8
4. Penicillin	12	1	8.3	9
5. Aureomycin®	12	2	16.6	9

The complication rate is lower in the hospitalized group than in the outpatient group (with the exception of Aureomycin®) and the duration of illness appears to be shortened. However, since the groups are small the statistical validity may be questioned.

The lower complication rate is due to better general care and more rigid control of the patient while in the hospital. Furthermore not all were seen again in two weeks so that this may make the complication rate lower than it actually was, when compared to the private outpatient group.

COMMENT

THE evaluation of the various methods of managing uncomplicated upper respiratory infections in 301 private patients showed a complication rate of 14 per cent in the treated and 13.8 per cent in the control group plus the aspirin group. Furthermore the complications developed sooner in the Gantrisin® and antibiotic-treated groups and were predominantly classified as viral. Additional support to this observation is the higher ratio of initial white blood counts below 10,000 in this group. It is believed that the antibiotics and Gantrisin® upset the bacterial-viral balance or symbiosis and eradicated potential bacterial complications but enhanced the possibility of viral infections. This reasoning would, in part, explain the shorter recovery time in the control group.

There was an increased incidence of complications in the control children with high white blood counts. This is significant. It would appear safest to *obtain white blood counts on all patients with upper respiratory infections.* If these counts are high, it would be wise to obtain nasopharyngeal cultures and antibiotic sensitivities, thus insuring proper and adequate antibiotic treatment.

Chloramphenicol appeared to be the best all around antibiotic. In 108 sensitivity tests encompassing hemolytic streptococcus, hemolytic staphylococcus, streptococcus viridans, H. influenzae, proteus and pyocyanus, chloramphenicol was the drug of choice in 89 cases. Additional information is being assembled on this point.

The hospital group was too small to be of significance. These subjects showed the same general trend as in the outpatient groups. Hospital care plus the lack of the two to three week follow-up may have contributed materially to the lower incidence of complications.

Among the children who developed complications and had initial white blood counts over 10,000 in the control and aspirin-treated group, the pathogenic bacterial incidence was 70 per cent. Of these 52 per cent were hemolytic streptococcus.

CONCLUSIONS

IT IS difficult to reconcile the immediate use of chemotherapeutic agents and antibiotics in children with elevated temperatures and essentially negative physical findings. However, it can be concluded that:

1. The complication rate in children following uncomplicated nasopharyngitis will be about 14 per cent with or without antibiotic therapy.
2. The initial white blood count may be used as a guide for the institution of antibiotic or chemotherapeutic therapy. In the control and aspirin-treated group, the incidence of complications was 87.5 and 90 per cent respectively in children with an initial white blood count greater than 10,000.
3. Treatment of complications is best begun when they appear and not with the inception of elevated temperature.
4. Antibiotic and chemotherapeutic agents lower the complication rate in patients with an initial white blood count over 10,000 but apparently increase the complication rate in children with white blood counts under 10,000.
5. These findings support the contention that if the white blood count is under 10,000 and physical examination reveals an uncomplicated upper respiratory infection therapy should be aspirin and supportive therapy rather than the indiscriminate use of antibiotics or chemotherapeutic agents.

The State School

Manuel J. Rowen, M.D.

William W. Weissberg, M.D.

Elizabeth

Preliminary Study of the Use of Carbutamide® in Diabetic Patients

Perhaps we are approaching the dream of an oral antidiabetic, the dream of freeing the diabetic from the tyranny of syringe and needle. And perhaps not. Carbutamide® is a promising drug—but Dr. Rowen and Dr. Weissberg are properly cautious about its use and restrained in their recommendation.

Recent reports in the medical literature[1,2] have shown that a sulfonamide compound, N-sulpha-Nilyl-N-n-butylurea, known as BZ-55, has the ability to lower blood sugar levels in adult human subjects. Most of the work done on normal, as well as diabetic patients, has been reported from Germany.[3] This drug has been issued for clinical investigation by Eli Lilly and Company as Carbutamide®.

A discovery such as this must have far-reaching, revolutionary effects on the everyday practice of a physician. Diabetes is a controllable disease in most instances, but it has always required the use, or the threat of use of a syringe and needle. Although this does not seem very grave to a physician in his daily rounds, the physical threat of the ever-present needle has been a moderate barrier in the treatment of diabetes. Beginners in this disease are prone to procrastinate in the use of the needle and syringe because of natural timidity. The possibility that an oral antidiabetic would be discovered has always been a hope. Therefore, the heartening news of these antidiabetic compounds has been warmly received.

We have treated a small but well-controlled group of private ambulatory out-patients to observe problems that might arise and test the efficacy of Carbutamide® in practice.

History

Various synthetic chemicals, notably the sulfonamide derivatives, have been observed and studied because of the hypoglycemic effect when given orally to animals.[4,5,6] Loubatieres[7] recently published a review of his studies done as early as 1942, in which he used various experimental sulfonamides to produce hypoglycemia. Janbon[4] was able to produce antidiabetic effects while he treated patients in 1942 with a sulfonamide known as 2254 RP. German investigators published a large series of human cases with startling blood sugar

1. Rudolfo, A. S. and Kirtley, W. R.: Journal of the American Medical Association, 160:1285 (April 1, 1956)
2. Kinsell, L. W. *et al.*: Science, 123:585 (April 1956)
3. Frank, H. and Fuchs, J.: Deutsche Medizinische Wochenschrift, 80:1449 (Oct. 7, 1955)
4. Janbon, M. *et al.*: Montpelier Medicine Francaise, 21:489 (November 1942)
5. Bovet, D. and Dubost, P.: Biology, 138:764 (October 1944)
6. Chen, K. K. *et al.*: Proceedings of the Society for Experimental Biology and Medicine, 63:483 (November 1946)
7. Loubatieres, Antoine: Archives Internationale du Physiologie, 14:58 (January 1956)

reduction, as well as clinical control in a majority of patients. Preliminary reports from American sources began to appear as early as April, 1956, and produced renewed interest. A very thorough and encouraging report of cases was made by Unger and Davidson [8] on a chemically-related sulfa in which a methyl group was substituted for the amino in BZ-55.

PHARMACOLOGY

Carbutamide® (BZ-55) has a hypoglycemic effect on normal human subjects as well as diabetics. It has no action in the totally depancreatinized animal or alloxandiabetic animal, so it is assumed that it will only work in the presence of insulin, either endogenous or exogenous. The exact site of action is unknown, but it is postulated that it acts as an anti-insulinase substance blocking the insulin destroying property of the insulinases, or as a stimulant to the beta cells of the pancreas. The mode and mechanism of action of the drug is still not known; blocking action on the adrenals and pituitary or on a glucagon effect or endogenous insulin is not proved.

CLINICAL APPLICATION

THE drug should be used only where almost daily blood sugar levels are obtained. Diets with increased carbohydrates (160 to 200 Grams) and reduced fats help the action of Carbutamide.® Presumably it acts only as an adjunct and not as a substitute for insulin. The resulting hypoglycemia is due to the action of the insulin itself either through anti-insulinase effect or by formation of additional insulin by the beta cells of the pancreas.

The compound is readily absorbed from the gastro-intestinal tract with demonstrable blood levels in 30 minutes after a dose of 2 Grams. Maximal blood level is attained in 3 to 4 hours and begins to taper off in about 7 hours. The blood sugar levels also respond in a like fashion with maximum effect in 2 to 3 hours and disappearance of the effect in 6 hours. The blood "sulfa" level is still 50 per cent of maximum about 24 hours after the single dose of 2 Grams. Because of this residual blood level noted after a single large dose, the daily maintenance dose may be smaller. The long acting property acts as a depot in the body. In the normal patient who is given this drug, there are occasional mild hypoglycemic effects.

The group in whom best results are anticipated are those who have developed diabetes in adult life and where the diabetes is not severe. The shorter a period of time during which the patient has had diabetes, the more effective the medication. *This drug is not a substitute for parenteral insulin.* It is an adjunct to treatment. The German literature contains histories and reports of over one thousand patients that have been treated with it. Results apparently have been good in those patients who still retain some insulin-producing ability. Young patients, "brittle" diabetics, and asthenic patients did not show favorable responses. Patients who were in diabetic acidosis are not suitable candidates for Carbutamide®. If the drug is going to be effective, the blood sugar levels begin to decline within a few hours. Optimum level is reached in four to six days.

Contraindications to this oral compound are conditions in which there is a severe emergency, such as acidosis, surgery, or infection. It is also contraindicated in patients with known renal, or liver disease, as well as the juvenile, "brittle" diabetics.

Dose is 2 Grams daily for two days followed by one Gram daily thereafter. Medication is given in two divided doses at the beginning, but when 1 Gram was given, it could be taken at once. There were no immediate side reactions reported or noted. Caloric diets of the American Diabetes Association were used and activity was carried forward in the same fashion. There were two patients who were on Carbutamide® plus small insulin dosage.

TOXICITY

THE incidence of toxic reactions shows wide variation with different reporters. Some of the German investigators [9] encountered up to 7.3 per cent of drug fevers and eruptions, but

8. Unger, R. H. and Davidson, J. W.: Journal of the American Medical Association, 162:447 (September 1956)

9. Bertram, F. *et al.*: Deutsche Medizinische Wochenschrift, 80:1455 (Oct. 7, 1955)

symptoms subsided with discontinuation of therapy. Swiss workers[10] report only rare and mild side effects in the treatment of 100 cases.

The initial work in the United States has shown that the incidence of side reactions and toxicity is slightly higher than that reported from the foreign literature. There have been three known cases of death presumed due to Carbutamide® in which the cause of death was agranulocytosis. These patients had developed a mild leukopenia, and it is thought that the disease progressed to agranulocytosis. Another was shown to have an interstitial myocarditis, which may be due to sulfonamide toxicity. There is also a vague syndrome reported in which the patients have become "ill" with what appeared to be an upper respiratory infection with fever, malaise and lethargy, as well as nausea and vomiting, from which there has been recovery.

The structural relationship of "sulfa" compounds always contains the potential for varied and serious side-effects. Leukopenia may occur after the patient has been on the Carbutamide® treatment for about one month. This leukopenia may progress[8] to agranulocytosis so that when this white cell reduction is noted, it is recommended that the drug be discontinued. The remission of the leukopenia is prompt. The total reported incidence of toxic side reactions in the short term follow-up of 6,850 cases is 5.2 per cent.[11] Reactors are usually of the hypersensitivity type and include leukopenia, anemia, skin rashes, drug fever and a syndrome consisting of malaise, lethargy, nausea and vomiting. In view of the large number of cases, the serious toxicity is very low, but further results are still forthcoming. Possibility of late damage caused by the drug, or gradual or sudden failure of action cannot be excluded because of insufficient time of follow-up.

SUMMARY

TREATMENT for diabetes mellitus with Carbutamide® was given to twelve ambulatory private patients. Ages ranged from 42 to 73 years of age. Five of the 12 were females. Eight were "new" diabetics, *i.e.* one to two months' duration. Nine previously had had no diabetic treatment. Therapy with Carbutamide® was given for from one to four months. Most of the patients were overweight. The drug was discontinued in two obese diabetics when it was determined that they could be controlled by diet alone; and it was discontinued in two other patients because of the described toxic side reactions. One patient died of acute left ventricular failure while on Carbutamide® therapy. She was an advanced cardiac. All of the patients had one or more associated diseases including hypertension, cardiovascular and peripheral vascular disease, gout, obesity, diverticulosis, bronchitis, bursitis, and pulmonary fibrosis. Carbutamide® had no effect on these associated conditions. Ten of the twelve patients were more than 10 per cent overweight.

Carbutamide® therapy alone resulted in good control in eight patients and poor control in four. Carbutamide® was effective in producing better control and lowering the previously used insulin dosage in two patients.

It was difficult to obtain good cooperation from the patients for the frequent blood sugars and blood counts necessary for adequate control. It is imperative to check the blood count weekly, to pick up early adverse changes. There were no cases of severe hypoglycemic reactions, acidosis, or diabetic coma during the therapy.

CONCLUSIONS

ORAL Carbutamide® (Lilly) therapy was found effective in "new" or recent overweight diabetics. It was not used in children or in any of the complications of diabetes. Carbutamide® is an effective ancillary treatment in a definite proportion of overweight diabetics who require small doses of insulin (up to 25 units). However, it carries a risk which is

10. Constann, G. R. *et al.*: Schweizsche Medicinische Wochenschrift, 86:699 (June 16, 1956)

11. Personal communication dated August 27, 1956 from W. R. Kirtley of Eli Lilly and Company to the senior author.

too high to permit the drug to be used in routine office practice where the patient cannot be checked weekly. The drug may be tried on an ambulatory basis with complete understanding by the patient of the absolute necessity of frequent follow-up and a thorough knowledge of the symptoms and signs of the possible toxic effects.

A recent personal communication[11] from the manufacturer of Carbutamide® has requested that no new patients be started on the drug because[11] three deaths have been reported in the group of patients receiving this drug. Although the findings were not entirely clear-cut, the possibility exists that Carbutamide® contributed to the findings at autopsy.[11]

133 W. Jersey Street

Show Business and Brotherhood*

As Jackie Robinson says, the national pastime of baseball has done much to overcome racial prejudice. Our Southern neighbors struggling with the problem posed by the Supreme Court decision, might ponder the experience of the most bitterly competitive and heterogeneously populated business in the world—show business.

Despite their individual temperaments, egos and types of talent, you never hear about showpeople acting up or playing down to a fellow performer because of race, creed or color. They eat together, play cards together, drink together and share in the others' triumphs and failures. There's even a team composed of an Arab and a Jew (Allen and DeWood) currently climbing up the ladder of laughs.

For reasons the psychiatrists might explain, many of the singing stars are either Negroes or of Italian extraction whereas the names that make the biggest news in comedy are Jewish. I can think of only four well-known comedians, off-hand, of Italian descent: Jimmy Durante, George DeWitt, Jerry Colonna and Romo Vincent. Berle, Benny, Joe E. Lewis Danny Kaye, Jerry Lewis, Red Buttons, Sam Levenson, Buddy Hackett, the Ritz Bros., Jerry Lester, Morey Amsterdam, Jackie Miles, Eddie Cantor, Phil Silvers, Alan King, Jan Murray, Joey Adams, Joey Bishop, Al Bernie. Jack Carter, Gene Baylos, Jack E. Leonard. Henny Youngman, Sid Caesar, Dick Shawn, Groucho Marx and George Burns—all are Jewish.

The men who dominate the recording field, aside from Eddie Fisher, Tony Martin, Elvis Presley, Bing Crosby, Robert Merrill and Johnnie Ray, are either Negro or Italian. In the first group you will find Billy Daniels, Louis Armstrong, "King" Cole, Cab Calloway, Bill Eckstine, Sammy Davis, Jr., Al Hibbler, Harry Belafonte, William Warfield. In the second category are Perry Como, Frank Sinatra, Vic Damone, Frankie Laine, Dean Martin, Ezio Pinza, Julius LaRosa, Tony Bennett and Alan Dale.

Regardless of the denomination or color, the only mission in the lives of showpeople is to lighten the load of worries and to release, with a song or a smile, the tension under which today's world is living. It's the spirit, more alive than ever before, that Irving Berlin immortalized when he penned the lyrics to the national anthem of the profession, "There's No Business Like Show Business."

*Hy Gardner ("Herald Tribune"). This is published in the interest of Brotherhood Week.

Jiro Nakano, M.D.

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Jersey City

Routine Pre-Operative Electrocardiography*

With age no longer a barrier to surgery, the pre-operative cardiac assay becomes especially important. In this unique study, the Jersey City Medical Center group turn up the surprisingly high incidence of 37 per cent cardiac abnormalities at "routine" studies.

With the great advances in recent years of surgical and anesthesiologic knowledge, more extensive surgery is being performed successfully on patients in older age groups. Pre-operative cardiac evaluation of these patients has become important. During the past year and a half, all Jersey City Medical Center patients admitted to surgical floors for pre-operative evaluation, in addition to the usual clinical and laboratory workup, were studied electrocardiographically. The analysis of 2,000 consecutive electrocardiograms thus obtained is the basis of this communication. We here stress: (1) the importance and the value of routine electrocardiograms for all surgical patients or those under surgical observation; (2) the age incidence of significant changes; (3) the frequency of arrhythmias, myocardial infarctions, electrolyte disturbances, and so forth; (4) the follow-up of patients with myocardial infarction whose disorder was discovered solely by routine electrocardiographic study.

From January 1955 to July 1956, 2,000 consecutive patients on the surgical services of the Jersey City Medical Center had one or more pre-operative electrocardiograms. Most later had major or minor surgery with various anesthetics. The minority were treated medically. The incidence of morbidity or mortality will be the subject of a separate report.

RESULTS

Table 1 reflects the age incidence of abnormal electrocardiographic findings in 2,000 consecutive patients. Most were in the older age groups. Abnormal findings increase with age, especially above the fifth decade. Sinus tachycardia and premature contractions are listed as "minimum" since they occur commonly without organic heart disease. They may indicate the necessity for further study by other methods. Significant abnormalities were found in 37 per cent of the cases.

The incidence of various arrhythmias is

*This work is from the Jersey City Medical Center. Dr. Nakano is a Fellow in Cardiology at that institution. The other authors are, respectively, the directors of electrocardiography, medicine and surgery.

TABLE 1.

ECG FINDINGS

Age Group	Normal (A)	Minimum (B)	(A+B)	Abnormal (C)	Total (A+B+C)	Percentage of Abnormality (C/A+B+C)
0-10	11	1	12	0	12	0
11-20	18	1	19	2	21	9.5%
21-30	77	5	82	12	94	12.7%
31-40	135	1	136	31	167	18.5%
41-50	196	20	216	71	287	24.7%
51-60	216	16	232	148	380	39.0%
61-70	252	40	292	219	511	42.8%
71-80	164	40	204	191	395	48.8%
81-90	41	18	59	74	133	55.6%
Total	1110	142	1252	748	2000	37.4%

(A) Electrocardiogram did not show any abnormal findings.

(B) Electrocardiogram showed only sinus arrhythmia, sinus tachycardia, or premature contraction.

(C) Electrocardiogram showed abnormal findings.

depicted in Table 2. Important disturbances in the conduction of the cardiac impulse were found in 8 per cent of the patients and of impulse formation in 5 per cent. Most common are the premature contractions which occur alone or in association with other more significant abnormalities.

In Table 3 is revealed the high incidence of abnormalities directly related to the myocardium, uncovered in this study. We found 108 myocardial infarctions (5½ per cent); 247 myocardial ischemias (12 per cent); 107 hypertrophies (5¼ per cent) and other changes listed in the table constituting another

TABLE 2.

Cardiac Arrhythmias

Arrhythmias	*Patients*
A. Disturbances in the impulse formation (449)	
1. Premature ventricular contractions	202
2. Premature auricular contractions	93
3. Auricular fibrillation	88
4. Sinus tachycardia	24
5. Sinus arrhythmia	18
6. Supraventricular tachycardia	7
7. Auricular flutter	6
8. Shifting pacemaker	6
9. Nodal rhythm	5
B. Disturbances in the conduction of the cardiac impulse (160)	
1. Right bundle branch block	78
2. Interventricular conduction disturbance	33
3. Left bundle branch block	24
4. Heart blocks	25
(a) Sinoauricular block	1
(b) First degree A-V block	18
(c) Second degree A-V block	4
(d) Third degree A-V block	2

TABLE 3.

Myocardial Infarction and Other Significant ECG Findings

	Patients	
Myocardial ischemia		247
Myocardial infarctions		108
1. Recent (28)		
(a) Anterior	14	
(b) Posterior	10	
(c) Subendocardial	4	
2. Old (80)		
(a) Anterior	34	
(b) Posterior	45	
(c) Antero-posterior	1	
Pericarditis		5
Cardiac aneurysm		3
Cardiac neoplasms, metastatic		2
Left ventricular hypertrophy		103
Right ventricular hypertrophy		4
Electrolyte disturbance		65
Digitalis effect		15
Chronic cor pulmonale		32
Acute cor pulmonale		1
Low voltage		5
Dextrocardia		1

5 per cent. Electrolyte disturbances are noted in 65 cases. This figure is probably low since these changes may mimic other electrocardiographic abnormalities.

In Table 4 the subsequent course of 80 of the 108 myocardial infarctions is presented. For various reasons the other 28 could not be followed. Forty-three of the 80 were operated upon; 39 had old infarctions and 36 survived surgery. Four had recent infarction and 3 survived. Thirty-four of the operations were "major" and 9 "minor." Anesthesia was general in 15, spinal in 20 and local in 8. This group tolerated surgery surprisingly well. This represented a selected group, the selection of which was aided by the electrocardiogram.

TABLE 4.

Results of Various Managements for Patients with Recent or Old Myocardial Infarctions

			Patients
A.	Recent myocardial infarction		21
	1. Operated upon	4	
	(a) Improved and discharged after operation	3	
	(b) Died after operation	1	
	2. Not operated upon	17	
	(a) Improved and discharged	9	
	(b) Died	8	
B.	"Old" myocardial infarction		59
	1. Operated upon	39	
	(a) Improved and discharged after operation	36	
	(b) Expired after operation	3	
	2. Not operated upon	20	
	(a) Improved and discharged	18	
	(b) Expired	2	

COMMENT

The value of the electrocardiogram in detecting myocardial infarction, arrhythmias, electrolyte disturbances and hypertrophies is well documented. Discovery of these abnormalities is especially important in the pre-operative patient. Though the pre-operative tracing may be within normal limits, it is invaluable for comparison with subsequent ones should electrolyte imbalances or cardiac abnormalities ensue during or after operation.

Most of our abnormal findings occur in the older age group. That these changes are significant and that they parallel the incidence of heart enlargement, diastolic hypertension and mortality has been demonstrated by Fox.[1] That many are unsuspected clinically and in the older age groups may be uncovered by routine tracings was shown by Rodstein,[2] who found 51 presumptive non-fatal infarctions in a group of 700 aged individuals. White, Edwards and Dry[3] concluded from an extensive pathologic study that the average grade of coronary sclerosis rises to a maximum "severe" grade in the 50 to 59-year group. It is suggested that as the degree of sclerosis increases, the collateral coronary circulation develops. This may explain the occurrence of most of the sudden coronary deaths before this time and the high incidence of non-fatal and atypical infarctions afterwards. Since the electrocardiogram is the most important single method in the diagnosis of myocardial infarction its routine employment pre-operatively is strongly urged.

SUMMARY

1. Electrocardiograms of 2,000 consecutive surgical patients were reviewed. Most of these patients were between 50 and 80 years of age.

2. In 37 per cent, significant abnormalities were evident in the electrocardiogram.

3. Of 108 patients admitted to the surgical wards with myocardial infarctions, only 43 had the surgery. Of these, 39 were classed as "old coronary" and 36 survived the operation. Four had recent coronary disease and three survived.

4. The importance of the routine electrocardiogram in the pre-operative study of the patient is stressed.

Baldwin Avenue

1. Fox, T. T. *et al.*: Annals of Internal Medicine, 17:236 (1942)
2. Rodstein, Marcus: Archives of Internal Medicine, 98:84 (1956)
3. White, N. K. *et al.*: Circulation, 1:645 (1950)

Charles A. Furey, M.D.

Philadelphia, Pa.

Electromyography in Neck and Shoulder Disorders*

By inserting a needle electrode into the belly of a muscle, it is possible to tap and record the action potential. This is the electromyograph. Dr. Furey here reviews the diagnostic usefulness of this instrument, particularly in shoulder and neck disorders.

Electromyography deals essentially with measuring the electrical currents generated by muscles. The instrument (the electromyograph), together with correct interpretation of the recorded findings (the electromyogram), aid the physician in assessing the functional integrity of the neuromuscular system. When interpreted in conjunction with the clinical findings, electromyography assists in the diagnosis, prognosis and treatment of neuromuscular disorders.

Clinical electromyography is established today as a diagnostic procedure. Pioneered by Denny-Brown [2] and others [1,3,4] in the 1930's, it proved of distinct value to the armed forces of the United States and Canada in the early 1940's [5 through 18] and in the decade since World War II has been perfected.[19 through 34] The rapid progress in this field has been achieved as a result of research in electronics, including the perfection of the unipolar needle electrode, as well as from increased knowledge of the physiology of the motor unit, together with the clinical application of these principles as applied to man.

The electromyograph is a compact unit. The apparatus consists essentially of an intake cable to transmit action potentials from a needle electrode that has been introduced into skeletal muscle. The cable is attached to a preamplification system, a sound amplifier, loud speaker and cathode ray oscilloscope. A tape recorder and synchronized camera complete the equipment. By utilizing the composite unit, the electrical activity of normal and abnormal muscles can be seen, heard, recorded and photographed.

The contributions of electromyography to neurologic diagnosis have been established and fully reported in the literature. One sphere of usefulness is worthy of emphasis: its use in neck and shoulder disorders. This is a region of frequent complaint by the patient and often perplexing in diagnosis to the physician.

A concept of the confused nomenclature prevailing in neck and shoulder disorders is grasped when it is recalled that certain of these conditions have been given as many as twelve different names. The electromyograph helps clarify the picture.

*Delivered before the American Congress of Physical Medicine and Rehabilitation, September 12, 1956, in Atlantic City, N. J. Dr. Furey is the Head of the PM-R Department of the Camden County (N.J.) General Hospital.

NECK-SHOULDER AREA

In the neck-shoulder area, the electromyograph is helpful in differentiating primary disorders, such as bursitis, tendonitis and the like, from other conditions, in which the symptoms are referred to the shoulder but the nerve compressing cause is elsewhere. The differentiation is accomplished by demonstrating with the electromyograph, the characteristic pathologic action-potentials, the presence of which points to an injured nerve. Furthermore, the location of the pathology and the degree of impairment is likewise conclusively demonstrated.

Better differential diagnosis of shoulder disorders attained with the electromyograph allows a more careful selection of cases. This, in turn, reduces the application of therapeutic roentgen therapy to the shoulder on an empirical basis. This potent therapeutic agent can then be reserved for patients who will derive greater benefit from it. Improved operative results in surgical procedures about the shoulder can likewise be anticipated, since the electromyograph enables the physician more accurately to select cases for operation.

Another important use of the instrument is in establishing a diagnosis in shoulder-neck cases where the history is obscure, the physical findings meager, the x-rays negative, and the laboratory findings normal. Following is a case history of a man with shoulder weakness, in whom a definite diagnosis could not be established by the classical procedures.

CASE ONE

A 41-year old man complained of difficulty in lifting the telephone receiver with his left hand, an action essential to his job. This complaint was of several years' duration. The only other symptom was an occasional but uncomfortable "click" in the left shoulder. He found that it was easier to pick up the telephone receiver with his right hand, balance the receiver upon his right shoulder, and then return his hand to the desk to transcribe the message. There were no other complaints. He had had an injury to the left shoulder twelve years before.

Physical findings were negative, except for motor function at the left shoulder. The motor function test revealed mild weakness in abduction of the left arm at the shoulder, graded as G minus. There was also weakness in external rotation of the left arm at the shoulder, graded as G. X-rays of the shoulder, with the arm in various positions, and numerous special films were negative. Electromyogram revealed denervation fibrillation and positive sharp waves in 20 per cent of the areas sampled in the anterior deltoid, in 20 per cent of the middle deltoid fibers and in 30 per cent of the posterior fibers. Furthermore, there were positive findings in the upper teres muscle.

A diagnosis of compression of the left circumflex nerve, secondary to the shoulder injury of twelve years before, was established. The patient was placed under treatment and in four weeks, the motor functions of the left arm abductor and external rotators were equal to or greater than that of the uninvolved arm. He sensed no further "clicking" in the shoulder, and encountered no further difficulty in lifting the telephone receiver or other objects with his left hand in the normal manner. Two years later, this man continues to be symptom free.

DIAGNOSIS OF NERVE COMPRESSION

When nerve compression injury results from athletic competition, the electromyograph aids the physician in establishing or confirming the diagnosis. For example, athletes engaged in football training frequently incur shoulder-neck injuries with associated nerve involvement. The usual complaints are weakness, numbness and tingling of the shoulder-neck region of one side and possibly of one arm. Usually, this first occurs during or shortly after a practice session, in which the candidate was occupied in fiercely charging a blocking-machine while running at top speed. A padded shoulder would come into forceful contact with the steel blocking apparatus. It is not unusual for several members of a squad to be ineffective at the same time because of this condition. Injuries of this type produce physiologic interruption of one or more nerves, and occasionally cause avulsion of an entire plexus. The brachial plexus may be affected. At other times, the long thoracic nerve may be injured. In the latter instance, pressure of the sharp cornered object upon the shoulder causes compression of the long thoracic nerve with paralysis or paresis of the serratus magnus and results in winging of the involved scapula, together with a surprising amount of difficulty in moving the arm and shoulder.

In this type of athletic injury, in the past, it was difficult to establish clinically what nerves or nerve groups were responsible for weakness and other symptoms. Today, the electromyograph helps clarify the picture and leads to more accurate diagnosis by pinpointing the involved nerves.

In these nerve compression syndromes, if the electromyogram is preceded by a muscle-function test, time is saved. The muscle-function test is a general guide to point out the more severely involved areas, which can then be examined in detail with the electromyograph.

CERVICAL-ROOT SYNDROME

THE cervical-root syndrome[35] has been frequently discussed[36] in recent medical literature. It has been described[36] as probably the most common cause of pain in the upper extremity, head and neck. The term, "cervical-root syndrome," or one of its numerous synonyms, refers to a mechanical abnormality producing pain, numbness or tingling by pressure on one or more cervical nerve roots or portions thereof. In cases of this type, the electromyogram confirms the nerve involvement and demonstrates the particular nerve root affected. Thus, by more accurately localizing the source of the pathology, the electromyogram reduces the number of etiologic factors under consideration.

CERVICAL-DISC DISEASE

CERVICAL-DISC disease is one cause of cervical nerve root involvement and may produce symptoms referable to the shoulder-neck region. In such cases, the electromyogram determines not only the presence of a lesion, but also its exact location. Here, the single nerve-root lesion is localized by demonstrating denervation fibrillation action-potentials in the myotome having common innervation from a single nerve root, with the absence of fibrillation from the adjacent myotomes.

SCALENUS ANTICUS SYNDROME

THE scalenus anticus syndrome is the most common condition involving the brachial plexus. The electromyogram assists in differentiating this syndrome from other lesions commonly affecting the same area. A comprehensive report by Shea and Woods[37] in the recent literature covers the subject.

CERVICAL ARTHROPATHY

ELECTROMYOGRAPHY is helpful in establishing a diagnosis of cervical arthropathy in the early stages, when this is difficult to detect clinically or roentgenologically. At this early stage, the patient may complain of stiffness, aches and pains in the neck and shoulder, and occasionally in the arm and hand. Routine x-rays of the cervical-neck-region are frequently normal. However, electromyogram points clearly to a nerve-root involvement and confirms the clinical impression of organic pathology. Roentgenograms at a later date will reveal impingement upon the nerve root in the intervertebral foramen. Here, then, the electromyogram assists in establishing an early diagnosis.

HIGH VOLTAGE CURRENT

EXPOSURE to high voltage current has a destructive effect on nerve cells. In such cases, when an arm and shoulder are involved, one leg will frequently be affected. Muscle atrophy may be extensive. The electromyogram reveals characteristic patterns, and assists the physician by recording the profound destruction of the motor units. It also aids in prognosis. If the electromyogram repeatedly reveals complete denervation fibrillation, and on attempted voluntary effort, no motor unit voltages appear within the proper period, it can be stated that the muscle is completely denervated and no recovery can be expected. Thus, where there is neuromuscular involvement due to high voltage current, the electromyogram reveals

important diagnostic and prognostic information.

HIGH CERVICAL LESIONS

ONE part of the body that presents many problems clinically and roentgenologically, is the upper region of the neck. In this area, diagnostic error is frought with grave consequence, for neurologic sequellae and traumatic arthritis are well recognized disabling complications. The electromyogram is a valuable procedure from the diagnostic and prognostic standpoint, in traumatic lesions of the high cervicals.

The following case history will illustrate this.

CASE TWO

A 45-year old man complained of pain and stiffness in the back of the neck, over the occiput and between the shoulder blades. He had numbness in the suboccipital region of the neck on the left side. These symptoms were present since a diving injury three weeks before. At the time of the injury, the patient was stunned but not unconscious. Numerous x-rays taken at that time were reported negative. Three weeks later, an electromyogram was carried out. At this time, he continued to have neck and shoulder complaints, including the numbness and abnormal skin sensitivity behind the neck. The head was abducted slightly to the right of the midline, the left sternocleido-mastoid muscle was prominent, the chin was tilted to patient's left, and there were areas in the suboccipital triangle of hypesthesia, hyperesthesia, hypalgesia and hyperalgesia. There was also a small area of purplish discoloration below the hairline.

Electromyogram revealed denervation fibrillation in 50 per cent of the areas sampled in the left splenius and longissimus capitis muscles, and in 40 per cent of the left longus colli. On voluntary effort, complex motor unit voltages were in evidence. Findings were consistent with compression of the nerve roots on the left side of the neck at the C-1 and C-2 level.

Following the positive electromyographic findings, x-rays were repeated with special views requested of the high cervical region. These roentgenograms revealed the presence of a rotatory subluxation of the first cervical with regard to the second cervical vertebra and involving the left apophyseal joint. There was no evidence of fracture.

This, then, is a case of a high-cervical-lesion in which the history and physical findings strongly suggested the presence of either fracture, dislocation or subluxation; but routine x-rays were reported negative. The electromyogram revealed unmistakable evidence of nerve compression arising at a definite location and a diagnosis of nerve compression, secondary to subluxation was established on this basis. This led to further roentgenologic study, which then confirmed the diagnosis.

GERIATRICS AND THE AGING PROCESS

SOME older people demonstrate pathologic electromyographic patterns. Marianacci [38] refers to "polyphasic activity being common in older people," and he feels that the findings are in some way related to the nutritional state. Shea and Woods [37] say that "certain older patients demonstrate widespread lower motor neuron disease despite the fact that clinically they have only a localized lesion." One authoritative source [39] feels that positive electromyographic findings in older people indicate a circulatory insufficiency which results in damage to the anterior horn cells.

Whatever the cause, all agree that the electromyograph reveals patterns in older people, which in any other age group are abnormal, and this stimulates further research.

The electromyograph, then, is an excellent medium by which to study the aging process in its various aspects, as for example, the response of the geriatric patient to diets, endocrine preparations and the like.

SUMMARY

ELECTROMYOGRAPHY has made rapid strides in the past two decades. It is a useful laboratory procedure in which the findings must be correlated with the clinical picture. Properly interpreted, electromyography is a distinct aid in the diagnosis, prognosis and treatment of certain diseases.

The electromyogram is particularly useful in differentiating conditions in which the symptoms are referable to the neck and shoulder, as for example, differentiating the more

frequently occurring shoulder lesions: bursitis, tendonitis, fibrositis and the like, from the less common shoulder complaints associated with involvement of the brachial plexus, axillary nerve or cervical nerve roots. Among the other neck and shoulder conditions in which this technic has proved of particular benefit are the cervical disc, cervical spondylosis, whip-cord injury, apophysitis, scalenus-anticus syndrome and nerve compression phenomena. In disorders such as these, the electromyogram will definitely locate the site of nerve damage, estimate the amount of damage, and assist in determining an accurate prognosis.

The electromyogram is to the neuromuscular system, what roentgenology is to the osseous system.

2201 St. James Place

A bibliographic list of 39 citations appears in Dr. Furey's reprints.

Bergen County Member Wins Poetry Award

The largest poetry award in the country is the Fellowship of the American Academy of Poets. The 1956 laurel went to Dr. William Carlos Williams, an essayist, a novelist, a poet and a member of our Bergen County Medical Society. Dr. Williams is the first physician ever to win this unique award. A general practitioner in Rutherford, Dr. Williams published his first book of verse over 40 years ago. He has written 37 books including poetry, short stories, essays and novels.

The award was made by vote of the Academy's distinguished board of chancellors. Previous recipients of the fellowship have been: Edwin Markham, Edgar Lee Masters, Ridgely Torrence, Percy MacKaye, E. E. Cummings, Padraic Colum and Robert Frost.

In 1926 Dr. Williams received the Dial Award; in 1931 the Guarantor's Prize for poetry; in 1948 the Russell Loines Memorial Fund Award of the National Institute of Arts and Letters; in 1949 he was made a Fellow of the Library of Congress; in 1950 he received the National Book Award and in 1953 he won the Bollingen Award for excellence in contemporary verse.

Distribution of Physicians in the U. S. A.

The current edition of the American Medical Association's *Directory* highlights some interesting changes in the distribution of physicians since 1950. Average *annual* net gain throughout the nation was only 2800. In the Pacific states there was a gain of 23 per cent in these six years; in the New England states, the gain was only 6 per cent. The greatest percentage gain was in Florida, which jumped from 3000 to 4500 physicians, a gain of 50 per cent. California's gain was 25 per cent but in gross numbers of doctors, this was the greatest increase of all: 17,000 to 21,000. Whereas California enjoyed a net gain of 4,000 M.D.s, the figure for New York state was only 934.

Since 1950, six states lost physicians: Missouri, Vermont, West Virginia, Iowa, Arkansas and—surprisingly—Illinois. The distribution between full-specialists, general practitioners, and all others continues on the one third-one third-one third ratio established at the end of the war. That is, a third of the doctors are G.P.'s; a third are full specialists; and the remaining third include interns, residents, part-time specialists, retired doctors Army-Navy personnel, and physicians on salary in industry, institutions or agencies.

Historical Article • • •

BENJAMIN LEE GORDON, M.D.

Ventnor

Roots of Russian Medicine

Dr. Gordon's research has unearthed some quaint and colorful items in the ancient history of Russian medicine.

All western superstitions were current in Russia during the medieval period with a large assortment of native hocus pocus in addition. The Russian people then believed in magic, sorcery, divination, astrology, the miraculous virtues of various herbs and formulas, the evil effect produced by "lifting the footstep marks" of an enemy, bewitched swords, love philtres, ghosts and vampires. Such factors still play a prominent part in Russian folklore.

Sorcery manifested itself in everyday life. Before a person went to court, he cut a trembling twig from a birch tree and recited the following formula: "As this twig trembles so may my adversary and his tongue tremble." When a woman was neglected by her sweetheart or husband, she consulted a sorceress[1] who would give her a root to place upon a mirror while reciting the words: "As I look into the glass and do not tire of seeing myself, so let my loved one never grow tired of seeing me."

As late as in 1598, the Russian had to pledge that in drinking, and wearing clothing he would engage in no evil practice against the monarch. He had to swear that he would not engage in sorcery nor employ "noisome roots" to the detriment of the Czar and that he would not hire wizards or witches to do harm unto him. He had to promise that he would not efface the Czar's footprints with any magical design and that he would not use magic or send any evil to him via the wind. The general public was refused admission to the Imperial stables lest some evil person place noxious herbs or roots in the emperor's saddles, bridles, belts or gloves. Even that enlightened Czar, Boris Godounof, was afraid of malign occult practices. He made all his servants swear never to have recourse to magicians, nor to any means of hurting the Czar and Czarina or their children and never to cast spells by working magic upon the tracks of their feet or their carriage.[2]

The Russian people had more confidence in the concoctions of wise women and in the holy water in which a relic had been dipped, than in doctors. If a doctor did not cure his patient, he was punished as a malicious magician.

One unfortunate physician was executed publicly by Ivan III for having allowed the Czarina to die. Another was accused of causing the death of a Tartar prince. He was delivered to the prince's relatives to be dealt with according to the rule of *lex talionis*. Even at

the end of the sixteenth century, when restrictions against doctors were relaxed the practitioner was the victim of prejudice. He was not safe from arbitrary punishment — particularly when he undertook the treatment of a member of the royalty or nobility. The physician was not allowed to see a noble lady's face or expose even the part of the body that was sick or injured. Her pulse had to be felt through a muslin covering. Yet, the physician was expected to make a correct diagnosis and perform a speedy cure.[3]

A GREAT change took place in Russia at the close of the tenth century when Christianity became the state religion. Medicine which had formerly been in the hands of the aged, "wise" women and sorcerers, passed into the control of the priesthood. Previous medical practices which included so much magic and sorcery were forbidden by the Greek Church. Czar Vladimir urged everyone to seek medical advice from the monks. He himself, however, employed a secular physician. Of course, in this practice he was far from unique. Even Popes often retained non-clerical physicians for bodily ills.

When Vladimir discovered that he was losing his virility he sent his physician John Simera to Alexandria to consult Egyptian doctors about his condition. The doctor, however, for reasons which are not hard to discern, refused to return.

The Kiev-Pichersky Abbey was the first monastery in Russia to practice medicine among the masses. Its founder, Holy Anthony (992-1072), upon returning from the Greek monastery at Athos, settled near Kiev and treated the sick with herbs, roots and leaves. His reputation as a physician spread widely, and the Kiev-Pichersky monastery grew up about him. His pupil, Holy Agapit (1095), carried on the work of Holy Anthony, treating the clergy and the laity in the monastery hospital.[5]

Medicine in Russia was originally practiced by the *volkhava* or wolfmen who, like the Druids of England, and the "*weisen frauen*" of Germany, gathered herbs to cure the sick and resorted to charms, spells and magic. On a vase excavated at Koul-Oba, there is a representation of a Scythian chieftain having a consultation with a *volkhava*, a Scythian warrior examining another's teeth and a surgeon bandaging an injured leg. This unique vase epitomizes medieval medicine and surgery in Russia up to the time of the School of Salerno.[6]

Russians of the Middle Ages ascribed disease to the displeasure of the gods and the malevolence of evil spirits. Attention was paid to the forces that caused disease. Sacrifices, incantations and spells were used. Spiritual effort was expended to cast out the evil forces. Russian medical folklore (still in vogue in rural districts and smaller communities) is of great interest to physicians, ethnologists and historians.

Kohl[7] relates that Russian villagers seek to protect themselves and their cattle against epidemics by drawing a furrow with a plough right around the village. The plough is dragged by four widows and the ceremony is performed at night. All fires and lights must be extinguished while the plough is making its circuitous course. The villagers believe that no unclean spirit can pass the furrow which has thus been traced. In the village of Dubrowitschi, a puppet is carried before the plough and members of the procession cry out: "Out of the village with the unclean spirit!" At the end of the ceremony, the puppet is torn to pieces and the fragments scattered about.[7] No doubt the demon of the disease is connected with the puppet and is believed to be destroyed with it.

SOMETIMES, in an Esthonian village, a rumor will spread that the "Evil One" himself has been seen in the place. Instantly the whole village is in an uproar. The people with sticks and scythes turn out to give chase to the devil. The "Evil One" is generally expelled in the form of a wolf or a cat. Occasionally the villagers brag that they have beaten the devil to death.[8]

The Khirgis of Central Asia, as soon as fever breaks out, leave the sick behind them in their frantic effort to escape the epidemic.

If a Georgian takes sick, the entire family is separated from the patient and an old woman is left with him. Regardless of its motivation, this practice is prophylactically sound. Those who leave the houses may be spared any communicable disease.

Among the heathen Wotyaks (a Finnish people of Eastern Russia) all the young girls of the village assemble on the last day of the year armed with sticks, the ends of which are split into nine branches. With these they beat every corner of the house and yard while declaring in a loud voice: "We are driving Satan out of the village." Afterwards the sticks are thrown into the river below the village, and as they float downstream, Satan goes with them to the next village, from which he must be driven out in turn. In some villages the expulsion is managed otherwise. The unmarried men receive groats, meat, and brandy from every house in the village. These they take to the fields, light a fire under a fir tree, boil the groats, and eat the food which they have brought with them. The associated incantation addressed to the devil is as follows: "Go away into the wilderness, come not into the house." Then the bachelors return to the village and enter every house where there are young unmarried women. They then seize the young women and throw them into the snow while declaring: "May the spirits of disease leave you."

On Good Friday people in Croatia and Slovakia take rods to church. When the service is over, they beat each other "fresh and healthy."[10] In some parts of Russia people returning from church on Palm Sunday beat the children and servants who have stayed home with palm branches while saying: "Sickness into the forest, health into the bones."[11]

Skorokhodov[12] relates that an Arab who came to the Volga district in the tenth century met a tribe of Russians who told him that if one of their number took sick they placed him in a tent out of town and supplied him with bread and water. They kept away from him, and his isolation continued until he either died or got well. This quarantine of the sick was decreed not because "contagion" in the modern sense was known but because of the belief that disease is caused by demonic possession and the populace was fearful that demons might pass from the body of the possessed patient to the healthy villagers.

Medieval men visualized demons as substantial entities. He who occupied himself with the practice of casting out evil spirits from the sick was careful to keep his mouth closed while carrying out the exorcism lest the demon pass from the mouth of the patient to his own. This practice is similar to that of modern physicians examining the mouth of a patient suspected of contagious disease—although, of course, the rationale behind the practice is different. The Khirgis of Central Asia still change their nomadic camping grounds whenever fever breaks out among them. They leave their sick kinsmen behind and flee to escape the terrible fever demon.

In later medieval Russia, remedies were composed of various metals and minerals including copper and iron. Iron was used internally and externally. Copper sulphates and acetates were used on the skin. Mercury was used externally and internally in syphilis. Gold was used in scurvy. Credence was given to the effectiveness of the magnet in curing all sorts of disease and it was a favorite means of expelling disease-demons. The magnet was also used by a husband to test his wife's faithfulness. The husband surreptitiously placed a magnet under his wife's pillow at night. If its presence did not disturb her sleep, she was considered true to her husband.

Medieval Russian women were familiar with devices to improve the position of the uterus in malposition. Ivanchenco described an operation performed by one woman upon another after the patient suffered a sudden violent pain in the abdomen. An abdominal incision was made and an extrauterine pregnancy noted.

Afansiev reports that to prevent sterility (which was considered by the Russians to be the greatest misfortune) the boiled testicles of a bear were given to the bride and groom. Testicles mixed in wine were regarded as a dependable remedy for sterility by the *boyers* (nobility) and royalty.

In some places the wound was washed with the warm urine of a child. Urine was considered to be a reliable remedy in a number of diseases. It was applied to burns and skin affections. Abscess was softened by the application of cow manure. Other wounds were treated with ointments.

In 1551, there was an outbreak of *klikusi* ("the possessed"). Those affected were principally elderly unmarried women — a group presumably vulnerable to hysteria. Victims of this ailment ran about barefoot and unkempt; they shook, they fell, they whirled, they writhed, and uttered predictions.

Of somewhat similar character were the prophetic powers ascribed in Russia to psychotics. Mentally ill were placed in the same category as the Roman *monstra*, as is borne out by the Russian terms applied to them: *jurodivy* derived from *urodu* which means "prodigy" or "monster." Psychotics inspired Russians with reverential awe. Their apparently incoherent ravings seemed to come from another world, and were interpreted as conveying supernatural knowledge.

During the reign of Boris Godounof, there lived in Moscow a schizophrenic (apparently) who was revered as a saint. Naked and with hair disheveled, he went about the streets in the coldest weather, uttering prophesies of coming woes. In an awe-inspiring voice he harangued Boris for the murder of his young Czarevitch. The Czar, either afraid of offending the people or else convinced of the man's holiness, did not attempt to interfere with him.[16]

In this period herbs, roots, leaves, turpentine, naphtha, arsenic, human blood, human and animal milk, dew drops, sulphur, pitch, hops (as given in an old manuscript in the Rumjanzaw museum), magical amulets made of roots and slips of paper inscribed with magic formulas were employed to combat or prevent disease.

THE RUSSIAN BATH

The steam bath, which probably originated in Russia, was more than a cleansing procedure. A common device for combating disease was the vapor bath. This was used for "washing away" disease as well as for religious purification. Brides were escorted by relatives and friends to the bathhouse the day before and the morning after the nuptial day. Baths, as a rule, were taken on Saturday afternoons and on the eve of the high holidays. Following the Saturday bath, strong efforts were made to prevent pollution until after Sunday morning services.[17] The sick were often littered to the bathhouse to be treated for colds, rheumatism, arthritis and similar diseases. It was believed that the application of external heat was an effective method for withdrawing heat from the body so fever patients were also brought to the bathhouse.

At the bathhouse, the local healer practiced phlebotomy, and the floors were literally covered with blood. It was customary for everyone to be bled at least once a month. Aside from bloodletting by scarification, the local healer was a master in the art of cupping. If the painful area was extensive, large cups the size of a pot were placed on the back, in some cases, leaving a lifetime scar.

Obstetrics was the monopoly of village women. The methods used by the midwife to "stretch" the uterus frequently led to disastrous results to the mother and her baby. The newborn was put through an unnecessary amount of handling. He was steamed with hot broth, shaken with head down "to prevent hernia," rubbed with salt, and fed fruit juice and other liquids.

The local midwife often brought her patient for delivery into the bathhouse because the steam was thought to be effective in stimulating labor pains.

It is related that when Czar Fedorovich suffered from a swelling in the groin (probably hernia), he was taken to the bathhouse where a pint of blood was taken from his veins, following which the swelling subsided. A patient with a hernia was customarily placed on a hot wooden bench and a wet rag was placed on the swelling. A ball of some fiber was then ignited in a cup or pot which was quickly placed over the wet cloth. This method was supposed to reduce the hernia. Most of these procedures were performed by women healers.[18]

IN EARLY times, according to Snegirev,[19] Russian men were accustomed to bathe with women in the same tank. This was forbidden by the Empress Elizabeth in 1743 and again by Catherine II in 1783. However, these edicts were not obeyed by the populace at large.

The public bathhouse consisted of a large room at one side of which stones were piled up which were heated from below by a furnace. On the other three sides were large wooden benches arranged in progressively higher rows as in an amphitheater. The steam or vapor was produced by pouring water upon the hot stones. While the room was filled with hot steam, the bathers rubbed themselves with brush-like appliances made of twigs or shrubs, bound tightly together like a broom. After the vapor bath, the bathers immersed themselves in a tank of warm water followed often by a tank of cold water.

Among the nothern Finns the *mesarana* or sweat bath was stationed in a log hut.[20] The entire family customarily visited the bath at one time.

When Christianity was introduced by Vladimir, folk-medicine received its greatest challenge. The new Church prosecuted the healing sages and wizards. The use of simples became a crime. Equipped with medical experience brought from Byzantium, the clergy undertook the supervision of medicine for the public. The Czar raised the position of church healers to the rank of ecclesiastics and placed them under the jurisdiction of the bishop. Vladimir's regulations condemned the use of herbs, witchcraft and magic. Magicians were outlawed, and sometimes burned at the stake. The Czar ordered the opening of hospitals at the monasteries and decreed that hospitals be placed under the supervision of the Church.

When epidemics broke out, ikons were placed in the districts where the pestilence prevailed. If even this failed to ameliorate the situation, a ban forbidding transportation of goods from the stricken area was enforced. Often, contraband goods were burned and with them the merchant, if he were detected transporting them.

There is no evidence that the medicine of the Russian monasteries ever attained the quality of that practiced in Western European cloisters. The Russian monks, by and large, were a God-fearing people who spent their time in prayer and devotion but had little inclination to read secular books. The Russian monasteries failed to produce personalities comparable to the scholastics of the Western European monasteries. The Russian clerics seemed little interested in the sciences. Aside from religious books, there were few works which interested them.

THE rise of the universities in Europe was influenced in a large measure by the scholastics who were the first teachers at the universities of Salerno, Paris, and Montpellier. Some European universities owe their existence to the local dignitaries of the Church. The Russian Church did not stimulate the development of universities to that degree.

The revival of Russian medicine was greatly influenced by forces from outside the country. The first mention of a trained physician was during the reign of Ivan III. A German physician named Anton Nemchin arrived in Moscow in 1485. He found favor in the eyes of the Grand Duke until he failed to cure the Tartar Prince, Karakech. Then he was turned over to the Tartars who took him down to the river and cut his throat. A similar fate under the same Czar befell a doctor named Leon Zhidovin. He was brought from Venice in 1490 by Andrei Paleolog, brother of the Grand Duchess to treat Ivan Ivanovich, the

eldest son of the Grand Duke. The prince appears to have been afflicted with rheumatic fever with arthritic involvement of his lower extremities. Cardiac complications ensued. He was treated by Leon Zhidovin with various internal remedies and hot applications externally. The treatment was not successful. The young prince died and the doctor's head was chopped off.

All the physicians attached to the medieval czarist courts were foreign doctors. Kings had no confidence in their local physicians. The foreign doctors, as long as their efforts were successful, were favorably treated. If their royal patients expired, the doctors were severely punished.

Shortly after Dr. Zhidovin was decapitated, the Russian ambassador, at the request of the Grand Duke, asked Emperor Maximilan I to send him a skillful physician learned in internal diseases and in the methods of treating wounds. In response to this request, the German ambassador, George Delator, in 1518, brought Nicolo Luyev of Lubek with him to Moscow. Luyev, who was a celebrated physician at home, appears to have enjoyed the great favor of the royal family. Perhaps more important than his medical skill was the fact that he knew how to get along with the political and ecclesiastic visitors to the court.

In the twelfth century, many foreign physicians came to Russia. A Syrian doctor named Peter Sirianin attended Prince Nicholas Davydovich of Chernigov. His patient later became his friend and entered a monastery with him in 1106. Sirianin is reported to have taken his patient by the hand whenever he examined him, probably for the purpose of palpating the pulse. Prince Svyatolpolk Yaroslavich died after a surgical operation on a swollen gland —an operation which probably had been performed by a foreign doctor.

The first code of Russian laws, *Russkaya Pravda,* recognized the right of the physician to receive compensation for treating a sick person: "The injured person is to receive three *grivny* and the *lekar* is to be compensated." This additional medical compensation later came to be known as *medicinal.* In general, it may be said that not until Yaroslavich's time did learned doctors appear in Russia and their influence at that period was in large measure due to the marriage of the Prince's daughter to the French King, Henry I, in 1051.

By the end of the Middle Ages, English physicians were welcome in Russia. The commercial relationship established with England in the year 1553, by the water route through the White Sea, opened Moscow to foreign physicians and artisans. The friendly relationship continued for three centuries.

Under Alexei Mikhailovich, the Russian Court included eleven doctors, six pharmacists and one "head physician." The outstanding doctors were Andrew Engelhardt, who was educated at Leyden and Koenigsberg; Samuel Collins of Cambridge and Oxford; Ivan Osenburg of Koenigsberg University; and the famous Lavrenti Blumentrost. Doctor Gregory Carbonari went to Moscow in 1689 on the recommendation of Emperor Leopold. In 1690, Jacob Pellarino, noted for his advocacy of smallpox innoculation, entered the service of Russia.

During the medieval period in Russia scientific medicine remained inaccessible to the civilian masses. Dissemination of medical knowledge in Russia was primarily a result of the recognized needs of the army. The first Czar to lay a sound foundation for the development of medical practice in the army was young Mikhail Fiodorovich, who sent *lekars* to the regiments. In his calculation of expenses in 1615, it is stipulated that the doctors attached to the army were maintained by the public treasury. In 1616 regimental doctors were enumerated in the muster. By the end of the seventeenth century, most of the regiments had attending physicians.

6917 Atlantic Avenue

A bibliographic list of 21 citations appears in Dr. Gordon's reprints.

Obituaries • • •

DR. M. DAVID BERK

At the age of 48, while visiting friends in Washington, D. C., Dr. M. David Berk died suddenly of a coronary attack suffered while eating in a Washington restaurant. Dr. Berk received his M.D. from Iowa in 1932. He entered the Army in World War II, rising rapidly from captain to full colonel. Dr. Berk was a pioneer in aviation medicine and was one of the early alumni of the Randolph Field course. He practiced in Pompton Lakes where he was school surgeon for many years. He was a member of the boro Board of Health, a trustee of the First National Bank, surgeon to the Police Department and examiner for the Civil Air Patrol. He was on the staff of the Chilton Memorial Hospital.

DR. G. IRVING LEVINE

At the untimely age of 52, Dr. G. Irving Levine of Jersey City died of a heart attack on December 2, 1956. Born in Bayonne, Dr. Levine moved to Jersey City in childhood. He received his baccalaureate degree at the University of Virginia in 1927 and his M.D. from Philadelphia Hahnemann in 1930. A Fellow of the American College of Gastro-enterology, Dr. Levine became increasingly interested in all branches of roentgenology, and was attending radio-diagnostician at the Fairmount Hospital, Jersey City, at the time of his death. During World War II, he was a major in the Army Medical Corps. He was active in the affairs of the Hudson County Medical Society.

DR. PHILIP MANGOGNA

On December 29, 1956, Dr. Philip Mangogna died of a heart attack at the untimely age of 48. Born in Newark, Dr. Mangogna was graduated in 1932 from the medical school of Tufts University. He interned at the Elizabeth General Hospital, and entered general practice in Newark. In 1939 he moved to Perth Amboy, where he became physician to the city's Department of Education. Active in committee work in the Middlesex County Medical Society, Dr. Mangogna was a past-president of the Perth Amboy Lions Club, Vice-president of the First Savings and Loan Association and a Fellow of the International College of Surgeons. Interested in surgery, Dr. Mangogna was a member of the Essex County Anatomic and Pathologic Society and on the surgical staff of the Perth Amboy Hospital.

DR. I. GRAFTON SIEBER, SR.

After half a century of service to the people of Camden County, Dr. Isaac Grafton Sieber, Sr. died on December 1, 1956 at the age of 79. Born in Pennsylvania, Dr. Sieber was graduated in 1902 from the Jefferson Medical College. After a brief period of practice in Philadelphia, where he served Jefferson Hospital, he crossed the Delaware and became a permanent resident of our state. For thirty years he was senior school physician to the town of Audubon. He was one of the founders of the National Bank in that town and in 1943 was elected president of that bank. Dr. Sieber started practice as a family doctor, but became increasingly interested in ophthalmology and otolaryngology. He served as laryngologist to the Camden County Hospital and was, for many years, active in the affairs of the Philadelphia Laryngological Society.

DR. ALVIN SIEGEL

At the early age of 30, Dr. Alvin Siegel died on December 8, 1956. Dr. Siegel was born in Brooklyn in 1926 and was graduated from Bellevue in 1951. He interned at Bellevue Hospital and then entered the field of otolaryngology, starting with a residency in 1952 at the Brooklyn Eye and Ear Hospital. After concluding the full three years of this residency, Dr. Siegel came to Cranford where, in October 1955 he opened his office for the practice of his specialty.

DR. ABRAHAM B. SPIEGELGLASS

Born in 1886, Dr. Abraham Spiegelglass of the Bergen County Medical Society died November 15, 1956. A graduate of the medical school of the University of Pittsburgh, class of 1908, Dr. Spiegelglass came east for his internship and elected to remain in New Jersey. He was one of the founders of the Bergen County YMHA. At first a general practitioner, Dr. Spielgelglass became increasingly interested in otology and in that capacity, was affiliated with the Postgraduate Hospital in New York City.

Announcements • • •

Pediatric Oncology

The Pediatric Department of the Memorial Center for Cancer and Allied Diseases announces a comprehensive three-day course in pediatric oncology for all doctors, to be held April 24, 25, and 26, 1957. This will include current developments and established methods in diagnosis, differential diagnosis and management of benign and malignant tumors Hodgkin's disease, leukemia and reticuloendothelioses in childhood. The course embraces ward rounds, seminars, demonstrations, examinations of children in pediatric, surgical, chemotherapy and radiotherapy clinics. The class is limited to 15 physicians. Fee is $35. For information address: Director, Pediatric Service, Memorial Center, 444 East 68th Street, New York, New York.

Philadelphia's Famous Institute

March 19 is the starting date of Philadelphia's famous graduate institute in medical practice. It will be held at the Bellevue-Stratford Hotel for the 4-day period ending March 22.

Subjects to be discussed are: metabolic disorders; drug therapy; allergic problems in clinical practice; treatment of skin diseases: common urologic disorders; advances in hematology; jaundice due to hepatic diseases; hormone therapy; orthopedic problems of general interest; progress in pediatrics; treatment of pulmonary diseases; radioisotopes in clinical medicine; and cardiovascular diseases.

The Institute is accepted for credit by the American Academy of General Practice. A large number of technical exhibits will feature the meeting. Registration fee is $10. More details are available from Dr. C. Wilmer Wirts, at 301 South 21st St., Philadelphia 3, Pa.

Fertility and Sterility Course

From May 18 to 31 a course in sterility and fertility will be held in New York City. It will include lectures, operative clinics, teaching of culdoscopic technics, ward rounds, practice in tubal surgery, and seminars on all clinical aspects of sterility and fertility. For more details, write to the Dean, New York Medical College, 1247 Fifth Avenue, New York (29) N. Y. Registration, being limited, will be on a first-come, first-served basis.

Cardiac Surgery for Indigents

National Jewish Hospital at Denver, a free, non-sectarian institution, is expanding its facilities for cardiovascular patients with lesions amenable to surgical intervention. Only patients unable to pay for private care are eligible. Since the hospital has a complete cardiopulmonary laboratory, definitive diagnosis by the referring physician is not necessary. Inquiries concerning admission should be directed to Director of Social Service, National Jewish Hospital, 3800 East Colfax Avenue, Denver 6, Colorado.

Harvey Tercentenary

If you are going to Europe this summer, you can participate in a meeting in London to celebrate the hundredth anniversary of the death of William Harvey. The Tercentenary will be spread over the entire week of June 3, 1957, at the Royal College of Surgeons in London. There will be a program of papers dealing with the historical, clinical and physiologic aspects of circulation. For more details, write to the Secretary, Royal College of Surgeons, 11 Chandos Street, Cavendish Square, London, W-1, England.

County Society Reports • • •

Atlantic

The regular monthly meeting of the *Medical Society of Atlantic County* was held at the Children's Seashore House on November 9, 1956, at 9:00 p.m. The President, Dr. Baxter Timberlake, presided. Speaker of the evening was Garfield G. Duncan, M.D., Professor of Medicine, Jefferson Medical College. His subject was "Practical Considerations in the Management of Diabetes."

The business meeting was then opened by Dr. Timberlake, who introduced David Scanlan, M.D., who gave the medical society plaque of honor to Dr. Shivers. Dr. Scanlan reviewed the many honors of Dr. Shivers during his professional career. Dr. Shivers brought the first approved residency to Atlantic City. He was the first member of our Society to become a Professor at a teaching institution, and he is still actively teaching at the Graduate School of Medicine of the University of Pennsylvania. Dr. Shivers has produced 28 papers and is now president of the American Urologic Society. Dr. Perez and Dr. Axilrod escorted Dr. Shivers to the platform where he received the honorary plaque. In his acceptance speech he expressed his gratitude for the honor coming from the local society.

Committee reports were then received and discussed. The President asked for approval of the minutes of the previous meeting. However, there was an addition to the minutes, and included the following paragraph. A motion was read and passed authorizing the expenditure of $300 to continue the annual contribution to the medical library of the county for the purpose of buying new books and magazines.

LEONARD B. ERBER, M.D.
Reporter

Bergen

The regular meeting of the *Bergen County Medical Society* held Tuesday, December 11, 1956, at Bergen Pines Hospital, Paramus was called to order by William T. Knight, M.D., president.

The Secretary read the following names, which had been approved by the Executive Committee for election to membership: To Associate — William N. Burke, Jerome Ferber, Sylvia K. Fried, John W. McDonald and Milton Greenberg; To Regular from Associate—Vance T. Alexander; To Regular by Transfer—E. F. Stanton.

The Secretary was instructed to cast one ballot for the election of this panel.

The Secretary read a resolution expressing the deep regret of the membership in the death of Dr. Abraham B. Spiegelglass. Dr. Spiegelglass was an active member of the Society for 41 years and emeritus member since June, 1955, and in practice in Bergen County for 44 years.

The meeting was turned over to Dr. Richard B. Berlin, chairman of the Scientific Program Committee, who introduced Dr. Henry J. Heimlich, Adjunct Thoracic and Cardiovascular Surgeon, Montefiore Hospital, New York. Dr. Heimlich's subject was "Medicine and Surgery Behind the Iron Curtain."

Dr. Heimlich's talk, which included both moving and still pictures, described some amazing surgery being done today in Rumania and covered the handicaps under which both Rumanian and Russian surgeons work. His description of the physician's life in the satellites and in Russia, together with the scientific aspects of his lecture provided a fascinating evening for his audience.

CHARLES P. CAMPBELL, M.D.
Reporter

Cumberland

The regular meeting of the *Cumberland County Medical Society* was held at Rainbow Lake on December 11, 1956 at 2:30 p.m., with the President, Dr. Sherman Garrison, in the chair.

The meeting and dinner which followed boasted a superb attendance of thirty-three members.

The minutes of the October regular meeting and the November Executive Committee meeting were read and accepted without correction.

A communication was read from Dr. Risely J. Madi, stating that he had a private plane and a private pilot's license and would be glad to offer this service in any medical emergency when practical. Dr. Madi is a member of the Aircraft Owners and Pilots Association and of the Flying Physicians Association.

The recent Diabetes Detection Drive, under the able direction of Dr. Sidney Siegel and his committee was very successful. Out of 97 persons tested, 3 definite cases of diabetes were discovered. Dr. Siegel commended the entire committee with special emphasis on the contribution by Dr. Ayars.

The credentials of associate members, Drs.: Richard Beck, Harry A. Capland, George H. Huston, George T. Varga and John H. Yeaman, were approved by the Executive Committee.

Dr. Costabile A. Cilento having been approved by the Executive Board is now an associate member of the County Society.

Dr. Marvin N. Solomon, Chairman of the Blood Bank Committee, reported a plan to set up a Blood

Bank in each county from which each hospital might be supplied.

Dr. Albert B. Kump, President-Elect of The Medical Society of New Jersey, reported on the interim meeting of the American Medical Association during November in Seattle.

The guest speaker, Dr. Edward W. Campbell, Head of the Department of Urology at Hahnemann Medical College, enlightened his contemporaries on "The Potential Dangers of Unrecognized and Untreated Urinary Tract Infections in Children." He pointed out how infections and anatomic gross defects in children tend to affect them in their adult life if they are not completely or are inadequately treated.

LEONARD G. SCOTT, M.D.
Reporter

Gloucester

The regular monthly meeting of the *Gloucester County Medical Society* was called to order by the president, Dr. Chester Samuelson on December 20, 1956 at the Woodbury Country Club. The speaker was Dr. Arthur W. von Deilen, Chief of Reconstructive Surgery at the Presbyterian Hospital in Philadelphia. He gave an excellent presentation on plastic surgery.

At the business session of the meeting, two physicians were elected to non-resident membership; Harry M. Burros, M.D. and Frederick G. Medinger, M.D. The recently enacted Social Security proviso for payments to disabled persons below the retirement age was discussed in terms of possible creation of a committee for review of cases of questionable disability. The Society finally passed a motion recommending that members use their own discretion about referring a case to another physician or specialist for an objective opinion.

A resolution was passed by the Society recommending that if the family of a deceased physician does not desire floral tribute and does not have a favorite charity, the funds be sent to the American Medical Education Foundation in memory of the deceased.

ROGER D. LOVELACE, M.D.
Reporter

Hudson

With Dr. John E. Annitto in the chair, *Hudson County Medical Society* held its regular monthly meeting in Murdoch Hall, Jersey City Medical Center, on December 4, 1956.

Dr. Valentina Makarenko of Guttenberg was elected to membership.

Dr. Saradarian directed attention to a sleep-inducing preparation, extensively advertised on radio and television, that contains scopolamine aminoxide hydrobromide in amount of 0.25 mg. per tablet, with recommended dose of two tablets before retiring. Stating that this amount of scopolamine could be injurious to sight in certain cases of glaucoma, Dr. Saradarian asked that the matter be referred to the Committee on Conservation of Vision of The Medical Society of New Jersey with a request for its opinion.

Guest speaker was Dr. Robert L. Rosenthal, Research Assistant Hematologist, Mt. Sinai Hospital. His subject was *The Hemorrhagic Diseases and Clotting Mechanism.*

HAROLD C. BENJAMIN, M.D.
Reporter

Middlesex

The final meeting for 1956 was convened by Dr. Sidney D. Becker, president, December 19 at the Roosevelt Hospital, Metuchen.

Dr. B. F. Slobodien, Chairman of the Judicial Medical Ethics Committee proposed the following applications for regular membership from associate membership: Drs. Irvin Goldsmith, Metuchen; Donald F. McDonnell, New Brunswick; Samuel Silverman and Howard D. Slobodien, Perth Amboy. They were unanimously approved by the body.

A communication was read from the Sussex County Medical Society seeking support for Dr. Jesse McCall for second vice-president of The Medical Society of New Jersey. A similar letter was received from the Mercer County Medical Society in behalf of Dr. Moriconi. The Society voted to file these letters.

Dr. Arthur J. Patek, Professor of Medicine at Columbia University, was introduced and delivered an address on "Cirrhosis of the Liver — Medical and Surgical Treatment." This timely discussion was well received.

Dr. Calvin reported that the Committee for the revision of the Constitution and By-Laws was making satisfactory progress.

Dr. Calvin moved that the usual Christmas gifts be given this year. Dr. Miller seconded this motion and it was passed. Dr. Stanley Gadek moved that the Trustees of The Medical Society of New Jersey be asked about "disability certificates" signed by chiropractors being accepted by the State Disability Commission. This motion was passed.

MORTON M. KLEIN, M.D.
Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held November 20, 1956 at the Passaic County Valley View Hospital. Dr. Abraham Shulman, the President, called the meeting to order.

Elected to active membership were Drs. Hugo M. Cardullo, Rita Grant Newman of Pompton Plains; Jerome Bellet, H. Louis Chodosh, Lewis L. Immerman, Francis E. Kelly, Anthony F. Pernetti, Michael J. Pirozzi, of Paterson; Harry B. Gurland and Richard H. Small of Passaic; Richard J. Lempke of Packanack Lake; David I. Canavan of Franklin Lakes, Paul Glicksman of Rutherford. Elected to Associate Membership was Dr. C. June Moore Cardullo of Pompton Plains.

Resolutions were adopted on the deaths of Dr. Jacob J. Greengrass and Dr. Leo V. Becker.

Dr. Shulman read a letter from the American Medical Education Foundation, expressing its appreciation for the contribution of $100 made by the Society in honor of Dr. David B. Allman.

The President gave a short resume of the report of the meeting of the Welfare Committee of The Medical Society of New Jersey, held September 23, 1956. He pointed out some of the activities undertaken by the State Society and the A.M.A. in the interest of its members.

The meeting was then turned over to Dr. Homer H. Cherry, who introduced the guest speaker, J. Maxwell Chamberlain, M.D., Director of Surgery, Brooklyn Thoracic Hospital and Assistant Clinical Professor of Surgery, Columbia University. Dr. Chamberlain's subject was "Case Selection and Surgical Treatment of Heart Disease."

After the question period Dr. Cherry invited the members to supper, which proved to be a very satisfying dinner.

DAVID B. LEVINE, M.D.
Reporter

Salem

A talk by Joseph M. Bransky, District Supervisor of the Philadelphia office of the U. S. Bureau of Narcotics, featured the regular meeting of the *Salem County Medical Society* on December 21, 1956, at the Du Pont—Penns Grove Country Club. Mr. Bransky emphasized the severe penalties that have recently been made mandatory when a person is convicted of sale of narcotic drugs in a federal court. New Jersey law makes revocation of a doctor's medical license mandatory if he is convicted of this crime in either state or federal courts. He cautioned doctors to be suspicious if the apparent narcotic needs of a sick patient increase strikingly, citing cases where members of the patient's family had begun to help themselves to the patient's narcotic medications to relieve their own turbulence. He made clear his attitude, apparently shared by most of the members present, that the peddler of narcotic drugs deserves no sympathy. Mr. Bransky also stated that the user of such drugs is a positive menance to society and represents a "carrier" of the state of drug addictions. These persons will not hesitate to habituate others to indulge their own expensive habit.

Mr. Bransky said that the narcotic addict does not drift into his habit unwittingly, through the efforts of "drug peddlers who lurk around schools" as one often reads. His operatives, skilled in undercover work and trained to pose as prospective buyers, have great difficulty in ferreting out sellers of narcotic drugs. New Jersey defines any user of narcotics as a disorderly person. Any doctor who is approached by a patient for narcotic administration or prescription should immediately call police to have the person detained as "a disorderly person" and should notify the Federal Bureau of Narcotics so that agents may determine whether the individual is a fugitive from prosecution. At least 70 per cent of narcotic addicts have criminal records prior to entering upon the use of narcotics.

Dr. Isadore Lipkin presided over a short business meeting at which Dr. John S. Madara reported on the progress of the state's "Medicare" program for dependents of men and women in the Armed services, now being administered by the Medical Service Administration. Dr. Madara reported that the state Welfare Committee had advised local hospitals to develop departments of psychiatry and had advised county medical societies to study the recent developments in disability legislation.

W. L. SPROUT, M.D.
Reporter

Widows and Orphans

At the meeting of the Trustees of the *Society for the Relief of the Widows and Orphans of Medical Men of New Jersey* customarily held before the holidays, a larger donation than ever before was made as a Christmas gift to five needy widows of former members. They have been getting regular benefits from the Society. The majority have received this aid over a period of years. One is a helpless invalid. Two hundred dollars was voted to be sent to each one for Christmas. Payments during 1957 were authorized to be made quarterly. The entire amount totalled $3,100.

At the meeting, the Trustees learned that about $9,600 was received from the estate of the late Dr. Joseph C. Young of Newark, a former member. This, together with $2,000 from the Society's contingent fund, swells the permanent fund to near $100,000.

While benefits of this effective, worthy and time-tested "Helping Hand" society are given immediately to the family of a departed member, they may also be extended without limit over years to a widow or orphans if need be. Present members can feel satisfaction in furthering this good work.

EARL LEROY WOOD, M.D.
President

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

The Management of Menstrual Disorders. By C. Frederic Fluhmann, M.D. Pp. 350. Philadelphia, Saunders, 1956. ($8.50)

This current contribution on menstrual disorders is an up-to-date consensus with which most obstetricians and gynecologists will agree. Every phase of the subject is fully covered, and the text is both readable and understandable.

Dr. Fluhmann says that the Ogino Knaus theory is well founded. The number of pregnancies occurring in those who follow this theory is too great to be explained away by anticipating the lengths of successive cycles.

The author is skeptical about retroversion as a cause of menorrhagia. Many of us have seen enough cases corrected by the knee chest position, only to recur if the malposition recurs. Dr. Fluhmann fails to mention intravenous pitocin for prolonged stimulation of uterine contractions, acting physiologically, plus the fact that it can be completely controlled.

The interesting observation is made by the author, that after total hysterectomy, the ovaries in most women lose function and show only atretic follicles. Subtotal hysterectomy, leaving a minute portion of endometrium, permits normal functioning ovaries possibly indicating an endometrial hormonal action.

This not too voluminous but very complete presentation should be useful to all interested in obstetrics and gynecology—especially to general practitioners, many of whom overuse hormonal medication. The book is a complete text for the uninitiated and a refresher for the specialist.

LEONARD ZWEIBEL, M.D.

Treatment of Heart Disease. By Harry Gross, M.D. and Abraham Jezer, M.D. Pp. 549. Philadelphia, Saunders, 1956. ($13.00)

Rapid strides in the treatment of heart disease make it difficult for a cardiology textbook to keep abreast of recent developments. Doctors Gross and Jezer, however, have done an excellent job of summarizing the latest methods of cardiac treatment. They have compressed many facts into a few pages.

The first part presents basic cardiac physiology and pharmacology. There are brief but clear discussions of cardiac output, heart failure and the important cardiac drugs, particularly digitalis and quinidine. This is followed by a consideration of the arrhythmias and their treatment. Management of the degenerative heart diseases is considered in detail and up-to-date treatment methods are critically discussed. A chapter on rheumatic fever is followed by one on subacute bacterial endocarditis and the other infectious diseases of the heart. The surgical management of congenital heart disease is described and evaluated.

An important chapter is devoted to the psychosomatic aspects of heart disease and the last chapter deals with rehabilitation of the cardiac patient. The appendix outlines diets most frequently prescribed for the cardiac patient. These include a variety of low sodium menus, a low cholesterol diet and a reducing diet.

For each topic, the pertinent literature is reviewed and compared with the authors' own experience. An excellent bibliography follows every chapter. This book is an excellent summary of cardiac therapy today.

ROWLAND D. GOODMAN, M.D.

Dermatology. By Donald M. Pillsbury, M.D., Walter B. Shelly, M.D. and Albert M. Kligman, M.D. Pp. 1331. Philadelphia, Saunders, 1956. ($20.00)

Difficulties and confusion in diagnosing and treating of skin diseases are due to poor training both preclinically and clinically in medical schools and during internships and residencies. To create a better foundation for understanding and intelligent handling of dermatoses the authors of this new book on dermatology — written for medical students and for physicians looking for information—devote one fourth of the pages to the principles of anatomy, chemistry, physiology, pathology, mycology, bacteriology, and immunology of the skin and to the principles of dermatologic diagnosis. Summaries at the end of respective chapters condense the facts for the superficial reader.

Black and white photographs, used throughout the book, are of highest quality. Those supporting the chapter on clinical examination and the chapter on types of skin lesions show in minute detail the characteristic elementary features essential for describing and understanding pathologic manifestations on the skin. Concise explanatory notes beneath the illustrations increase their didactic and visual value both for inspection or when reading the coordinated text.

The authors stress their preferred methods of therapy, even evaluating some methods as too risky or of doubtful effect. This is good leadership for the novice although some methods called "obsolete" or "of limited value" have proved effective in the hands of other experienced dermatologists, *e.g.* x-ray treatment of acne vulgaris.

The section on "cutaneous medicine" is written and illustrated in the sound way of elaborating on common dermatoses, covering briefly exceedingly rare ones and omitting some conditions which in the authors' view are no longer worthy of separate classification. I am tempted to ask whether syphilis has really become so rare as to be dealt with in only about seven pages of pictures and 23 pages of text outlining only the present-day ideas about syphilis rather than the disease itself? Besides these minor critical constructive remarks there can be only praise and admiration for this unique, successful and original approach of writing so refreshingly such an exhausting book containing completely and correctly the assured facts and knowledge of a specialty. This volume teaching the practical application of the observations, experiences, and preferred practices of the dermatological school of Dr. Pillsbury is a fountain of information and inspiration to the specialist which only he can appreciate. For the medical student and the practicing physician it means the most necessary opportunity of improving his standard of dermatology for the benefit of patients.

OTTO B. HITSCHMANN, M.D.

Home Health Emergencies. Published 1956 by the Equitable Life Assurance Society of America, New York 1 N. Y. Pp. 256. Gratis. Paper bound. Based on manuscript by G. W. Larimore, M.D.

If this book had an index, it would be an extremely useful ready reference guide. The first 50 pages consist of many shrewd tips on home nursing—how to dispose of wastes, keep records, make beds, and so on. Then comes an alphabetically arranged list of medical problems, starting with Abdominal pain, Abscesses and Artificial respiration, ending with Workshop accidents, Wounds and Zoonoses. For each item, there is practical material on what to look for and what to do until the doctor comes. If a layman is faced with bleeding from the head, for instance, he first looks in the index for hemorrhage. Since there is no index, he then looks for hemorrhage in the alphabetical arrangement of topics. Since this jumps from *heat exhaustion* to *hemorrhoids*: *piles*, the looker-upper may have a little trouble, but he will find it in smaller type. *Hemorrhage*: *see bleeding from* (and a long list of sources). Next, he turns, in the section of alphabetically ordered monographs to *bleeding from wounds* and if, by this time, the victim is still alive, he will find the information. The book is printed on a poor quality pulp paper and the illustrations are scanty and sketchy. However, the material is solid, sensible, authoritative and compact. If it only had an index!

HARVEY BLUESTONE, M.D.

Disturbances of Body Fluids. By J. H. Bland. Pp. 522. Philadelphia, Saunders, 1956. ($11.50)

In the not distant past, postoperative patients almost routinely received 5 liters of saline infusion in 24 hours largely on the basis—"it is good for them." Fortunately most of these patients had kidneys able to respond to the tremendous overloads imposed by injudicious amounts of sodium and chloride! Likewise, the medical patient was infused with parenteral fluids without much regard for the pathologic physiology involved. In this enlightened age of medicine, a fuller knowledge of basic physiology demands a more rational approach to fluid and electrolyte therapy.

This book represents a complete rewriting of the author's original, well-received publication, *The Clinical Use of Fluid and Electrolyte*, which was one of the first attempts to correlate in one volume many of the newer concepts of fluid balance. Beginning with fundamental physiological considerations, attention is directed to the pathologic physiology of water and electrolyte metabolism. Included —to mention a few of the major topics — are chapters dealing with the specific disturbances in congestive failure, renal disease, liver disease, pulmonary disease, diabetes and the surgical pediatric or geriatric patient. The text is complemented and clarified by the liberal use of schematic drawings and tables.

The author has presented a complex subject in an exhaustive manner. Undeniably, close attention is required of the reader lest he become lost in a maze of pathologic physiology. On the other hand, having digested the contents, the doctor is in a position to cope with disturbed fluid balance in a rational manner.

For the casual reader—no! For the serious student—yes!

GEORGE L. ERDMAN, M.D.

Cerebral Palsy: Understanding and Care. Viola E Cardwell, R. N. New York 1956. Pp. 625. Published by the Association for the Aid of Crippled Children. ($5.00)

Anoxia (rather than mechanical lesions at birth) is offered as the primary factor in cerebral palsy. This book is intended as a basic text for the training of all personnel concerned with helping spastic young people maximize their capacities. It is not a manual of treatment, however. The text is proposed for use in university courses and as a basic reference for those engaged in the several professions concerned with habilitation. It is arranged in three major divisions: the medical background and diagnosis of cerebral palsy; the individual with cerebral palsy and his total habilitation; the community aspects of cerebral palsy.

Comprehensively reviewed is the present status of surgical and medical treatment and of physical medicine in the evaluation and treatment of this condition. Miss Cardwell discusses, in some detail, today's therapeutic approaches. The presentation of the physiologic basis of neuromuscular activity and the function of other areas of the brain provides background for understanding the multiplicity of the varying combinations encountered. In addition, it gives a basis for evaluation of the

principles on which the different therapeutic approaches are founded.

Therapies in current use—physical and occupational—are covered in some detail, and the newer therapies—recreation and music—are dealt with more briefly. Well discussed are family problems, emotional factors, social problems, and vocational guidance. The community's role in providing a program of services as well as public and personnel education, comprises the final section of the book. Here is a brief sketch of the major nationwide organizations, with programs for cerebral palsy, from which local communities may secure assistance. Stress is laid on the preventive aspects and the great need for further research in this field.

RALPH N. SHAPIRO, M.D.

The Old Farmer's Almanac. By Robert B. Thomas. Dublin, N. H., 1956, Yankee, Inc. Pp. 110. (25c)

Each year advertisements seem to displace more and more of the quaint data which for 165 years have made this pamphlet a choice bit of Americana. This year's issue is filled with advertisements for salves to stop the itch, shoes, corsets for sacroiliac relief, drugs for "bladder weakness," pamphlets on the "drugless road to health," liquids for removing corns, booklets on the treatment of varicose veins, methods for the relief of arthritis, appliances for hernia, and other such high grade merchandise. If you can hack your way through the ads for special diets, hair dyes, false teeth adhesives, laxatives, rupture easers, and vegetable compounds, you will find a digest of motor vehicle laws and predictions of the weather all the way through to December 31, 1957.

ULYSSES FRANK, M.D.

The Art of Loving. By Erich Fromm, Ph.D. New York 1956. Harpers. Pp. 113. ($2.75)

Don't drool, gentlemen. This is *not* a book on sex, not a how-to-do-it or do-it-yourself manual. On the contrary, sexual adjustment is considered as a by-product of love, and love is thought of in the brotherly love or love-thy-neighbor category. The author's thesis is that love is a cultivatable art, a sense of oneness with, and responsibility for others. It is a character orientation, not an object relationship. Dr. Fromm distinguishes several kinds of love: brotherly, motherly, fatherly, religious, erotic and self-love. He writes with fluent plausibility, so that you enjoy reading the work. He stimulates such thought that every once in a while you have to stop, take stock, and think through what he means. He fears that our present competitive social and economic system make true love difficult, because our present culture is infiltrated with "the spirit of a production-centered, commodity-greedy society." True love, being collaborative, rather than competitive, is therefore not at home in a society where, he says "all activities are subordinated to economic goals." May the book have a huge sale, and the royalties roll in! To do him justice, even this will not change his viewpoint.

VICTOR HUBERMAN, M.D.

Head Injuries and Their Management. By Francis Asbury Echlin, M.D., Philadelphia. Lippincott. Pp. 127. 1956. ($3.00)

For only $3 you can get this slim, pocket-size volume on the practical management of head injuries. Intended for the general practitioner, it gives enough neurology and enough surgery to give the family doctor a solid basis for understanding. The material on rehabilitation is superficial and uninformative. The chapter on posttraumatic headache, nervousness and "neurosis" is somewhat amateurish. Apart from these two thin spots, the book is excellent. Dr. Echlin tells how to do a spinal tap, he indicates when not to do x-rays (a valuable section), he shows how to distinguish between surgical and nonsurgical lesions, and he lists 114 references and citations for those who want a more detailed review. The book is worth space in any doctor's bag.

HERBERT BOEHM, M.D.

Internal Secretions of the Pancreas. Edited by G. E. Wolstenholme and C. M O'Connor. Boston 1957. Little Brown. Pp. 292. Price not stated.

Recent research on the internal secretions of the pancreas is reported here by leading international chemists, biochemists, physicists and biologists. Although the biologic activity of insulin in relation to its structure is not yet clear, some progress has been made in understanding the agents which alter the alpha cells of the pancreas, glucagon, growth hormone, and the interaction of the various hormones. Piero Foà reports on the swift and significant decrease in blood sugar with intravenous injections of prolactin in normal dogs; and the subsequent liberation of insulin. Another achievement here cited is the analytic progress on the chemical constitution of glucagon. Two properties have been attributed to glucagon; a regulatory effect on carbohydrate metabolism, and influence on the growth processes. Carefully discussed here is the question of the secretion of insulin by the growth hormone and the interaction of the growth hormone and insulin in the organism. This book will be of value to research workers in this field. The Ciba Foundation is to be thanked for developing this colloquium and for thus stimulating international cooperation in scientific research.

W. ALAN WRIGHT, M.D.

TUBERCULOSIS Abstracts

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Chronic Progressive (Cavitary) Histoplasmosis As A Problem in Tuberculosis Sanatoriums

By Michael L. Furcolow and Charles A. Brasher, The American Review of Tuberculosis and Pulmonary Diseases, May, 1956.

Chronic progressive histoplasmosis, in contrast to acute progressive or disseminated form, occurs primarily among older persons and is localized to the lungs except in the terminal stages. Both forms of the disease, however, are eventually fatal. The early stage of the chronic form is characterized by apical or subapical pneumonic infiltrations which progress to multiple thick-walled, usually bilateral cavities.

In order to avoid further confusion in terminology the descriptive term, chronic progressive (cavitary) histoplasmosis, is proposed to designate this type of disease.

The symptoms of this form of histoplasmosis are cough, moderate weight loss, usually a slight elevation of the erythrocyte sedimentation rate, occasional temperature, profuse sputum, sometimes hemoptysis. The disease is characterized by exacerbations; the patient usually seeks medical help after an acute bout of what is called "influenza," at which time pneumonic or cavitary disease is found. This bout may subside and the patient not be seen again until several years later, at which time he has a similar episode and further extension is discovered. Quite often the cavitation is only in one lung at the start and, later on, following another bout of so-called "influenza," the disease spreads to the other lung. In the early stages large cystlike cavities may be seen, followed later by spread of the process.

The disease usually progresses to fatal termination and just before this occurs there is dissemination of the fungus throughout the body with enlargement of the liver and spleen. Frequently at post-mortem examination *Histoplasma* may be cultured from all organs of the body.

In this type of disease the sputum is usually loaded with *Histoplasma capsulatum* and positive cultures are readily obtained. Serologic tests are usually positive and serve as a good screening tool. Tubercle bacilli are occasionally found, but most of the cases are not complicated by tuberculosis.

Chronic progressive histoplasmosis closely resembles reinfection type of tuberculosis, and could be considered to be reinfection histoplasmosis. This classification is based on the finding in some cases of negative tuberculin tests, positive histoplasmin skin tests, positive serologic tests, positive cultures for the fungus, and the presence of chronic cavitary disease of the apices in association with calcified lesions in the hilar area. Autopsy on such patients fails to reveal evidence of tuberculosis and the criteria of "chronic reinfection histoplasmosis" appear to be fulfilled.

A total of only 16 cases of chronic progressive cavitary histoplasmosis has been previously reported. It is the purpose of the present paper to show that this type of disease occurs frequently among patients in a tuberculosis sanatorium.

The studies to be reported have been conducted at the Missouri State Sanatorium at Mount Vernon, Missouri. This sanatorium has an average daily census of 550 patients, 85 per cent of whom are white and 15 per cent are Negro. Casual studies begun in 1952 revealed an occasional case of histoplasmosis. Between March and August, 1954, a systematic survey of the patients at the sanatorium was undertaken. During the survey, skin tests were made. The mycologic laboratory services were augmented and careful attempts

were made to establish the diagnosis in all patients whose serologic tests were positive or whose diagnosis was in doubt in any way.

A case was termed "mycologically proved" if organisms typical of *H. capsulatum* were isolated by culture from the patient or were seen in tissues removed surgically or at autopsy. A "serologically proved" case was one in which the serologic tests for histoplasmosis were positive (1:8 or higher) on either of the complement-fixation tests or the precipitin test. Adequate cultural studies on the "serologically proved" cases usually revealed the presence of the organism. However, in many of these cases the patient had left the hospital before mycologic studies could be completed, or the disease was of the milder type from which positive cultures could not be obtained because of passage of time since infection.

These essentially casual studies for the presence of histoplasmosis in a tuberculosis hospital have now yielded a total of 19 "mycologically proved" cases and 95 "serologically proved" cases. These cases have been observed over a three-year period. During the three-months survey, 14 "mycologically proved" cases and 29 "serologically proved" cases were found. Of the 600 patients in the survey, 14 (2.4 per cent) were proved to have histoplasmosis by actual demonstration of the organism. In an additional 29 (4.8 per cent) the *diagnosis* of histoplasmosis was established by serologic tests.

In most cases the patients were more than fifty years of age, the males outnumbered the females, and all but one of the patients were white. In a number of cases, the onset of illness had occurred a number of years prior to determination of the etiology. The chest roentgenographic findings in almost all cases showed bilateral cavitation. Skin tests were positive to tuberculin in nine cases and to histoplasmin in 14 of the 18 cases tested. The serologic tests for histoplasmosis were positive in every patient. The organism was identified from every patient in most cases by culture from the sputum; occasionally, from cultures from the lung at operation or autopsy. The presence of the organism was demonstrated in tissue obtained at post-mortem examination in 2 cases in which fungal cultures were not done. The patients have been observed from a minimum of several months to a maximum of seventy-six months. Three patients have died. Progression of the disease occurred in nine of the 19 cases.

The finding that 7.2 per cent of the patients in a tuberculosis sanatorium have "serologically proved" histoplasmosis and that the actual presence of the micro-organism was demonstrated in 33 per cent of the cases is indeed remarkable. It certainly calls for very serious consideration of the importance of histoplasmosis in tuberculosis sanatoriums. If it be assumed that a similar prevalence obtained throughout the general area of high histoplasmin sensitivity, quite startling figures would be obtained.

Calculations have been made of the number of tuberculosis sanatorium beds in the areas where histoplasmin sensitivity among adults exceeds 50 per cent. This area extends roughly from southern Ohio in a sweeping circle through central Indiana and Illinois, eastern Kansas and Oklahoma, northeast Texas, northern Louisiana, Mississippi and Alabama, and includes all of Tennessee, Arkansas, Missouri, and Kentucky.

If the findings of the present study prove to be generally applicable to the histoplasmosis area, some 1,200 patients in tuberculosis hospitals would be found to have histoplasmosis. These 1,200 cases would obviously furnish an important reservoir for differential diagnosis as well as a complicating factor in any therapeutic trial of tuberculosis.

The accurate estimation of this problem is obviously of fundamental importance to all persons concerned with the care of the tuberculous. These patients not only occupy tuberculosis beds, but they derive no benefit from antituberculosis therapy and may contract the disease. Furthermore, the demonstration of more cases of histoplasmosis should furnish an adequate pool of cases for trials of therapeutic agents so urgently needed in this fungal infection. Moreover, the finding of histoplasmosis in the degree which might be encountered in this area might permit further usage to be found for beds in these sanatoriums. At present the general treatment of histoplasmosis is similar to that of tuberculosis before specific therapy was found.

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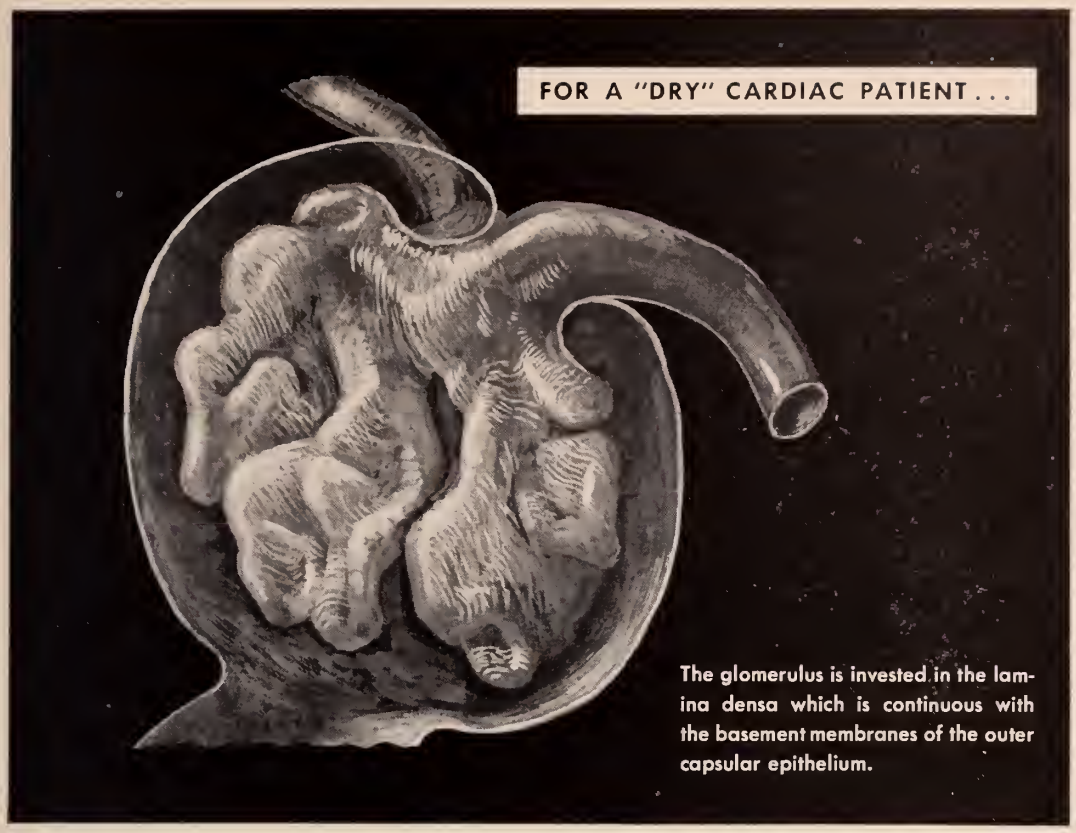


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1. Asher, G.: Personal communication, June 23, 1956.
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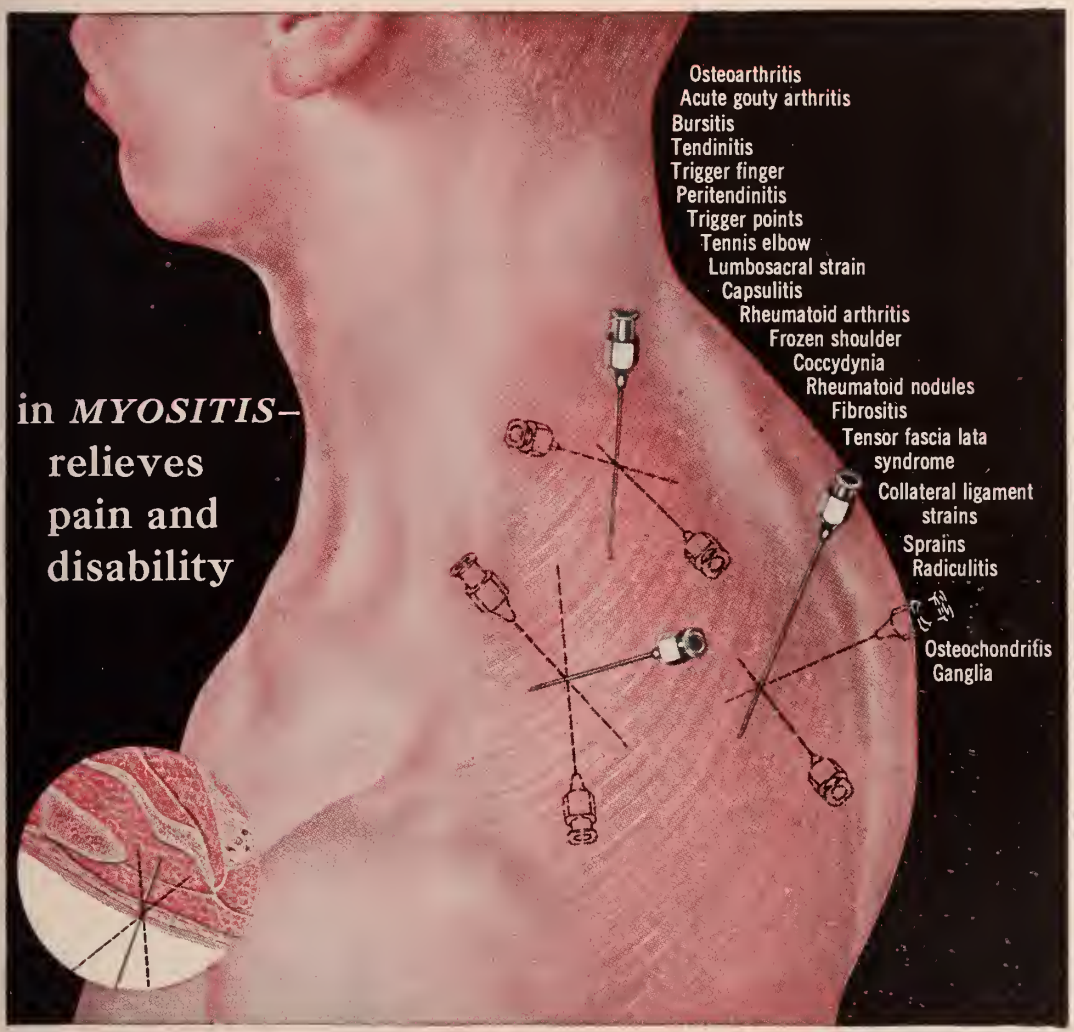
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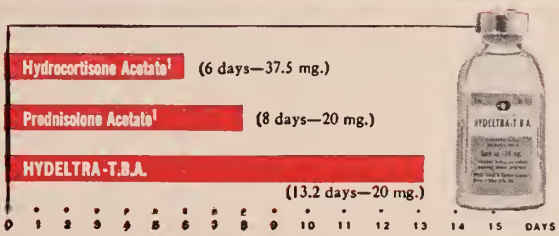
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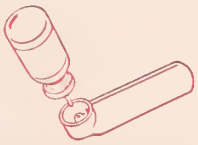


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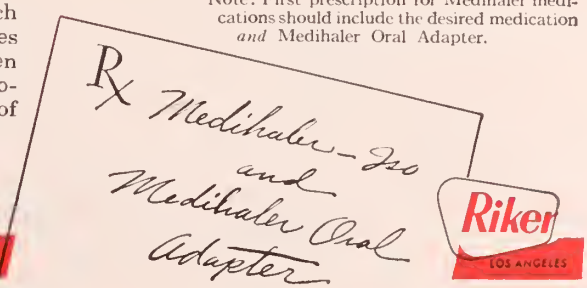
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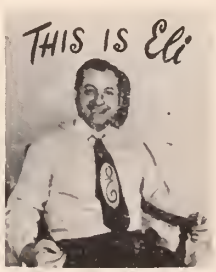
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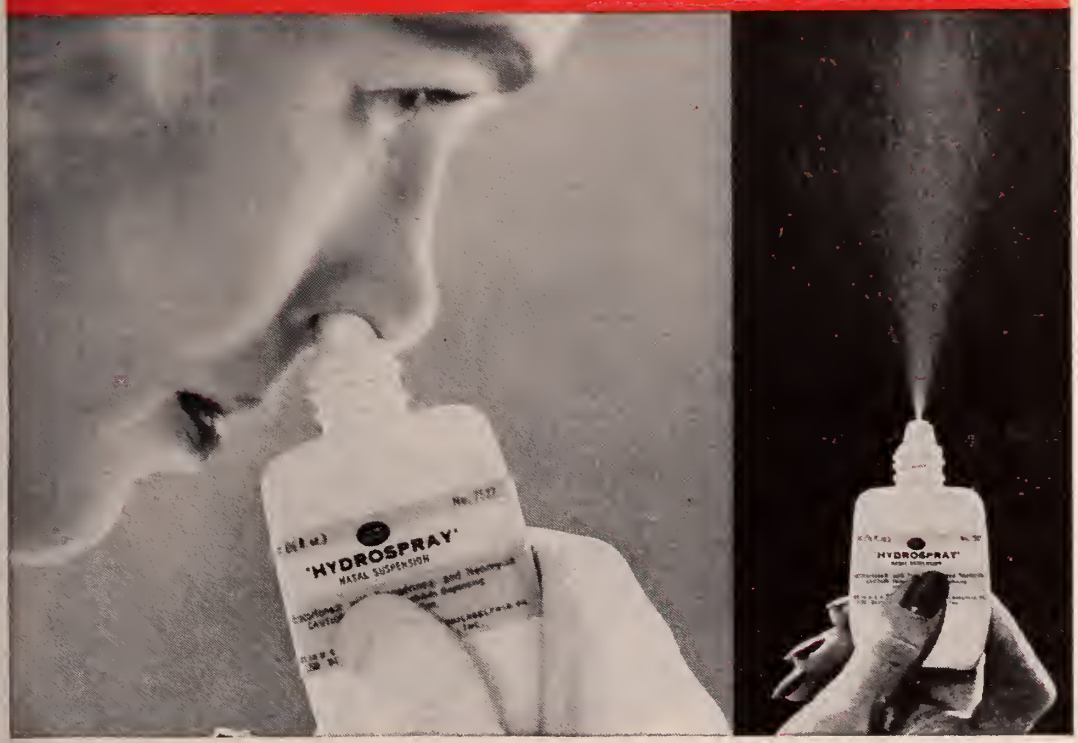
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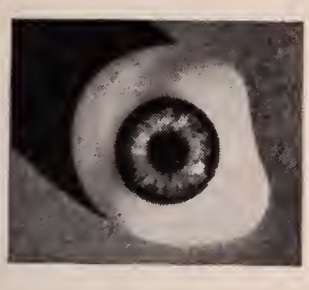
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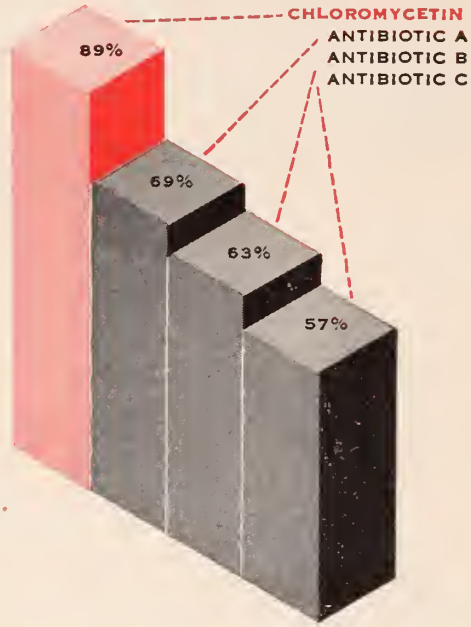
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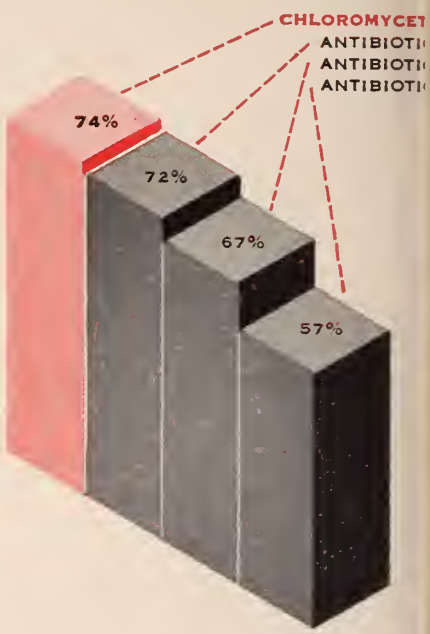
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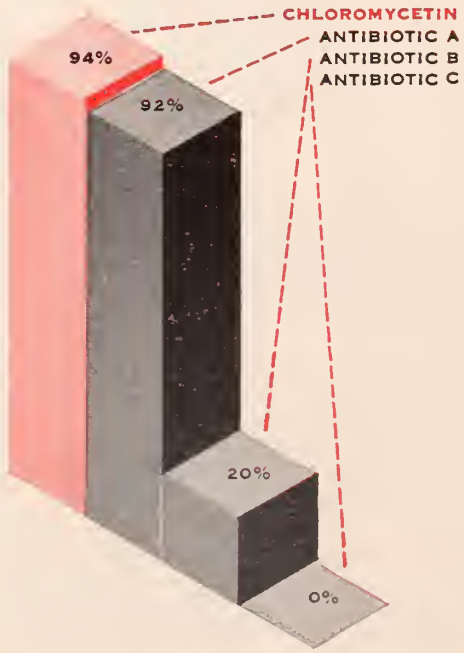
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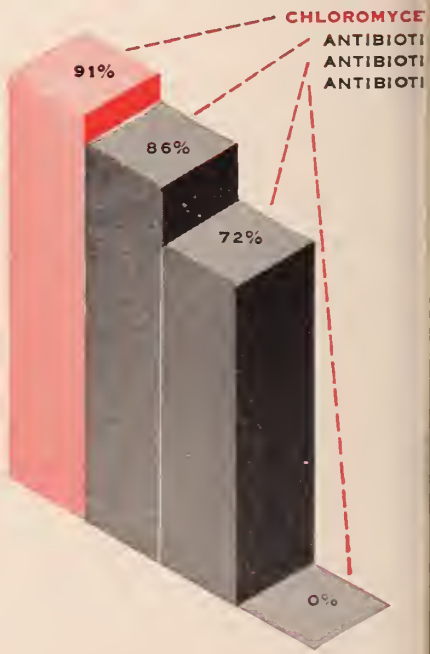
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THOROUGHLY SUPPRESSES THE PERPETUATING FACTORS OF PEPTIC ULCER IN CONJUNCTION WITH AN UNLIMITED AND UNRESTRICTED DIET

An alliance of anticholinergic, antacid and buffering agents, nutritional supplement and vitamin C, QUADRACINE creates the best possible conditions for the process of healing and facilitates it.

Clinical evidence indicates that in an ulcer regimen, dietary restrictions may interfere with and delay healing in addition to causing vitamin and protein deficiencies (1, 2).

QUADRACINE avoids or minimizes the necessity for enforced bed rest and rigid dietary restriction, permitting patients to remain ambulatory while providing rapid and thorough relief of pain and symptomatology, and x-ray evidence of healing (3, 4).

- **CLINICALLY STUDIED FOR 2 YEARS IN 300 AMBULATORY WORKING PATIENTS, WITH CLINICAL AND X-RAY DIAGNOSIS OF PEPTIC ULCER**
- **1 TABLET WITH ESSENTIAL INGREDIENTS FOR RATIONAL, EFFICIENT THERAPY**
- **SIMPLIFIED, COMPREHENSIVE TREATMENT FOR THE PATIENT**
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- **NO PATIENT RESISTANCE OR CONFUSION**
- **EASE OF ADMINISTRATION — 2 TABLETS Q.I.D., AFTER MEALS**

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A COMPLEMENTARY ASSOCIATION OF THERAPEUTIC AGENTS[1-6]

EACH TABLET CONTAINS:

Scopolamine methylbromide	0.93 mg.
efficient cholinolytic free from central nervous system effects.	
Aluminum hydroxide gel	200.0 mg.
Magnesium hydroxide	200.0 mg.
buffer and antacid for secure, complete neutralization.	
Milk protein dehydrated	100.0 mg.
important nutritional element deficient in peptic ulcer patients.	
Ascorbic acid	7.5 mg.
prevents common sub-clinical deficiency and contributes to the healing process.	

Supplied: Bottles of 100 and 1000 tablets

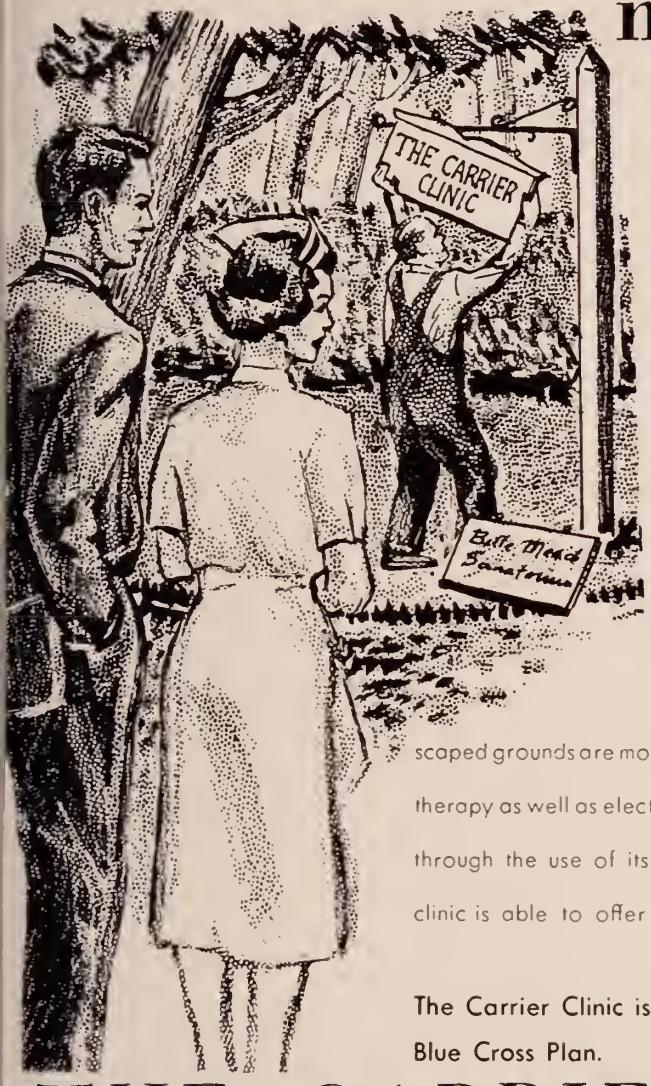
REFERENCES:

1. Field, H., Robinson, W. D. and Melnick, D.: Ann. Int. Med. 14:588, 1940.
2. Rosenblum, L. A., and Jolliffe, N.: J. A. M. A. 117:2245, 1941.
3. Manuscript in preparation for publication.
4. Manuscript in preparation for publication.
5. Council on Pharmacy and Chemistry: J. A. M. A. 159:1291 (Nov.) 1955.
6. Chapman, W. P., Wyman, S. M. et al: Gastroenterology 28:500,510,531 (April) 1955.

* *Patent Pending*

RESEARCH TO THE MEDICAL PROFESSION

A new *sign* in the search for mental health



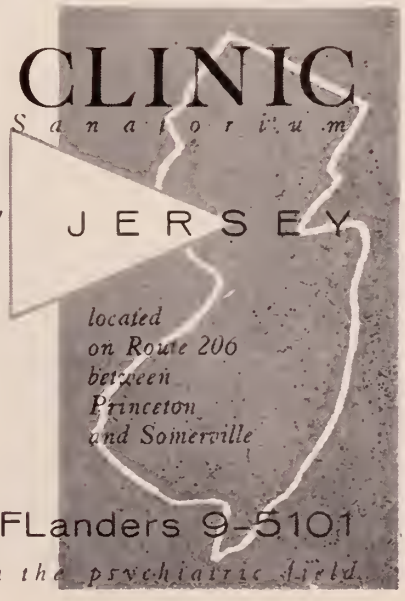
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Vitamin B_{12}	25 mcgm.	(INCREMIN Drops contain 1% alcohol)	
Thiamine (B_1)	10 mg.		

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- no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness
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Hospital Report Reveals Dannon Prune Whip Yogurt Successful in 95% of Chronic Cases When Taken Every Night for 3 Weeks

*An important study of chronic constipation at a New York hospital discloses these striking results:**

In a group of 194 chronically ill patients, averaging 71.6 years of age, regular feeding of Dannon Prune Whip Yogurt produced excellent results. Completely normal bowel habits were re-established in 187 patients, or 95.8%. They required no laxatives during the period of administration. Improvement in skin tone, seborrheic dermatitis, intestinal stasis and pruritus ani were also noted.

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Dannon Prune Whip Yogurt is a smooth, custard-like milk food—highly palatable. Made from fresh milk, with about 50% of the butterfat removed, it is low in calories, high in nourishment and has the delicious flavor of old-fashioned prune whip. You may recommend Dannon Prune Whip Yogurt for your most stubborn constipation cases with the same gratifying results described in the above report. Prescribed regimen is to eat one container nightly before bedtime, for three weeks.

Ferrer, F. P., and Boyd, L. J.: Am. J. Dig. Dis., 22:272, 1955

For literature, write Dannon Milk Products, Inc., 22-11 38th Avenue, Long Island City 1, N. Y.

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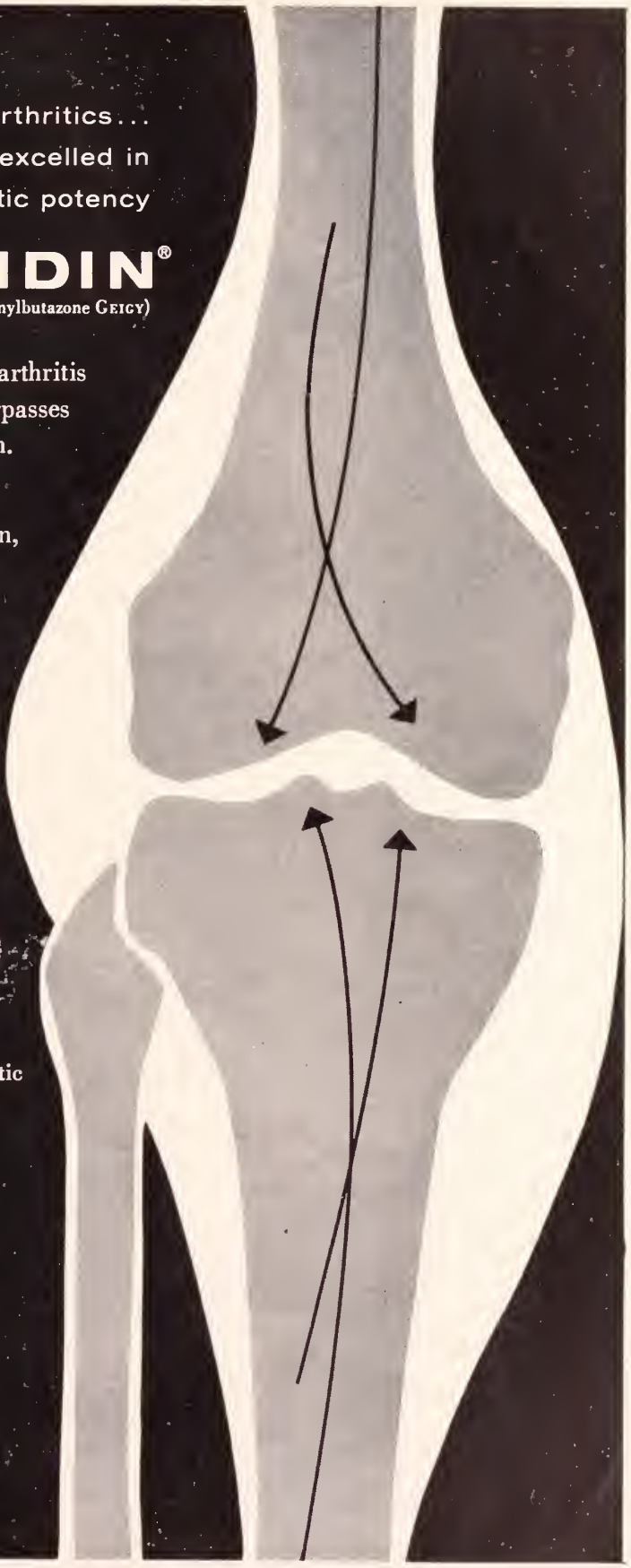
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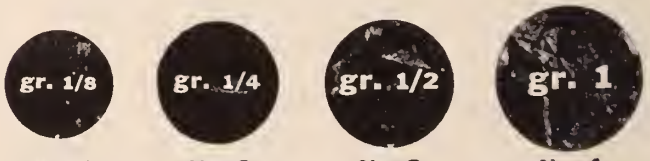
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EXPLODE

WITHIN 15 SECONDS' CONTACT WITH VAGISEC LIQUID

WITH THE Davis technique,† using VAGISEC® liquid and jelly, flare-ups of vaginal trichomoniasis rarely occur. VAGISEC liquid actually explodes trichomonads within 15 seconds after douche contact.[1] Better than 90 per cent apparent cures follow use of this new trichomonacide,[2] developed as "Carlendacide" by Dr. Carl Henry Davis, noted gynecologist and author, and C. G. Grand, research physiologist.[3]

No trichomonad escapes—The overwhelming action of VAGISEC liquid dooms the trichomonad. One chelating agent and two surface-acting agents combine in attack to weaken the cell membrane, to remove waxes and lipid materials from the membrane surface, and to denature the protein. With its cell wall destroyed, the parasite imbibes water, swells and explodes. All this occurs within 15 seconds. Only scattered fragments remain.

No other agent or combination of agents kills the trichomonad in this specific fashion or with the *speed* of VAGISEC liquid.[3] When the patient uses VAGISEC jelly as well—the recommended routine—these good effects continue indefinitely.[4]

Reaches hidden trichomonads—Unlike many agents, VAGISEC liquid thoroughly penetrates and dissolves the cellular debris and mucoid material lining the vaginal surface.[3] It reaches hidden trichomonads—often the cause of treatment failure—as well as parasites swimming freely in the canal.

The Davis technique—Office therapy with VAGISEC liquid is combined with home treatment. Both liquid and jelly are prescribed.

> OFFICE TREATMENT—*Wipe vaginal walls dry with cotton balls, then wash thoroughly for about three minutes with a 1:100 dilution of* VAGISEC *liquid. Remove excess fluid with cotton balls. Dr. Davis recommends three treatments the first week, two the second and one the third.*
>
> HOME TREATMENT—*Patient douches with* VAGISEC *liquid every night or morning and then inserts* VAGISEC *jelly. Home treatment is continued through two menstrual periods, but omitted on office treatment days. Douching is contraindicated in pregnancy.*

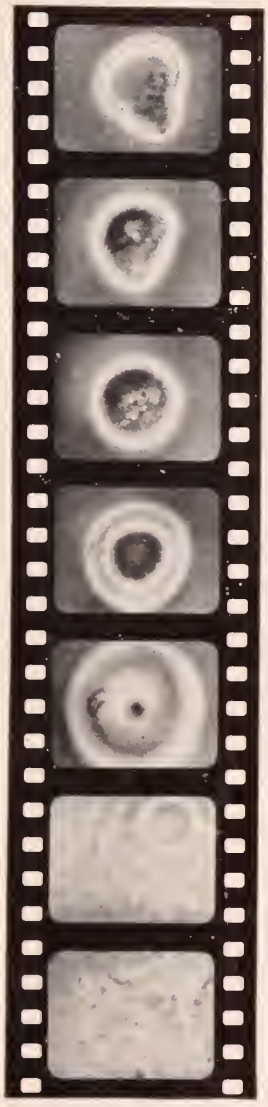
Husband re-infects wife—Since "trichomonads may be passed from the infected male to the uninfected partner during coitus,"[5] prevent re-infection by recommending the use of prophylactics. Specify RAMSES,® the finest possible rubber prophylactic, transparent, very thin yet strong; or XXXX (FOUREX)® skins, of natural animal membrane — pre-moistened. Your prescription of one of these brands insures the protection afforded by Schmid quality prophylactics and assures full acceptance of your regimen. At all pharmacies.

Active ingredients in VAGISEC liquid: Polyoxyethylene nonyl phenol, Sodium ethylene diamine tetra-acetate, Sodium dioctyl sulfosuccinate. In addition, VAGISEC jelly contains Boric acid, Alcohol 5% by weight.

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Top to bottom:
2 sec. CONTACTS
4 sec. COMPLEXES
6 sec. DISSOLVES
8 sec. DENATURES
10 sec. SWELLS
15 sec. EXPLODES
16 sec. SCATTERS

References: 1. Davis, C. H.: J.A.M.A. 157:126 (Jan. 8) 1955. 2. Davis, C. H.: West. J. Surg. 63:53 (Feb.) 1955. 3. Davis, C. H., and Grand, C. G.: Am. J. Obst. & Gynec. 68:553 (Aug.) 1954. 4. Davis, C. H. (Ed.): Gynecology and Obstetrics (revision), Hagerstown, Md., W. F. Prior, 1955, vol. 3, chap. 7, pp. 23-33. 5. Draper, J. W.: Internat. Rec. Med. 168:563 (Sept.) 1955.

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2 BONE CONDUCTION RECEIVERS. Occasionally people with impaired hearing get better results using a bone conduction receiver. This is a special headset for use with the new type amplifier phones and is available with or without a cut-off key.

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3 LOUD RINGING BELLS are available if the standard telephone bell cannot be heard.

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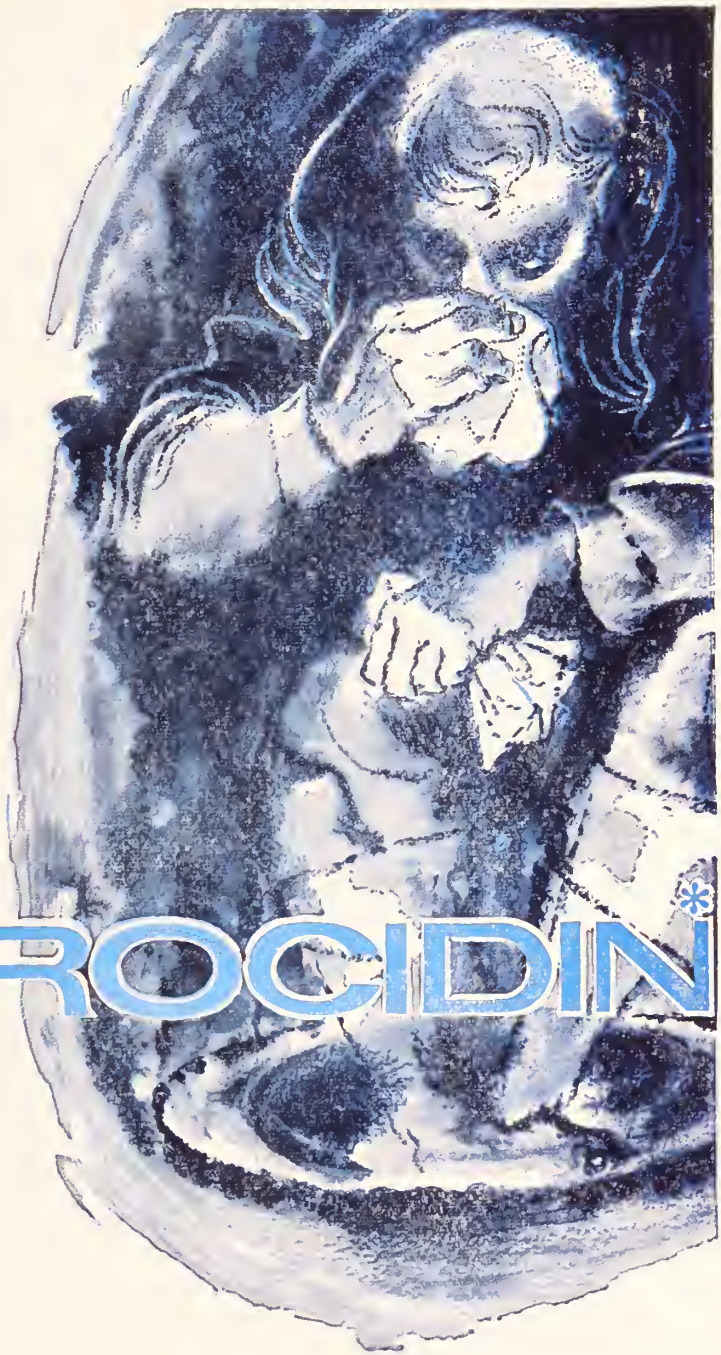
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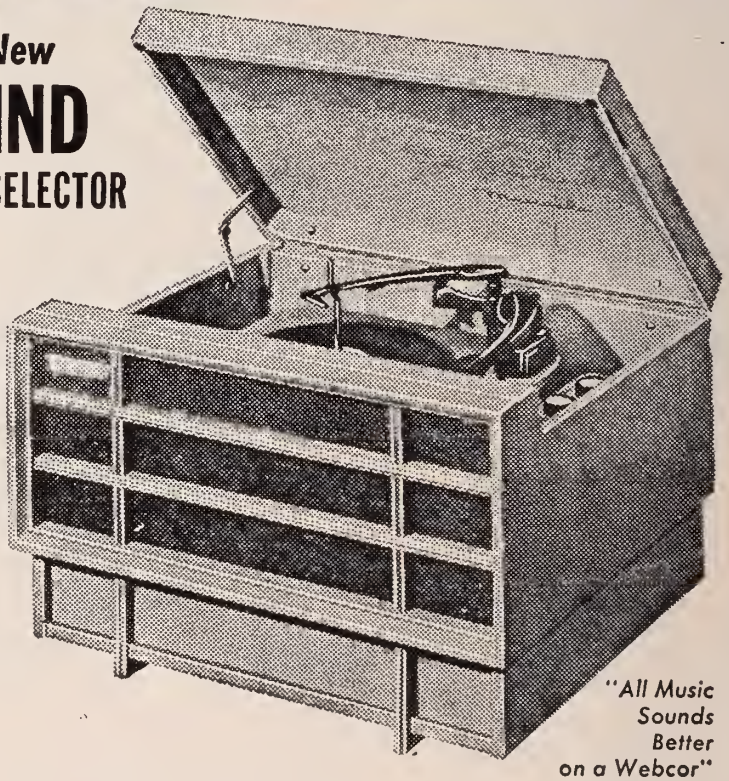
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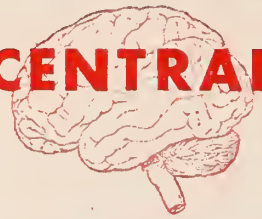
1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc., and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.



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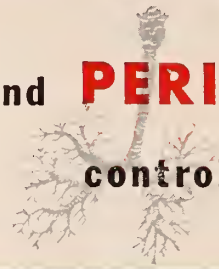
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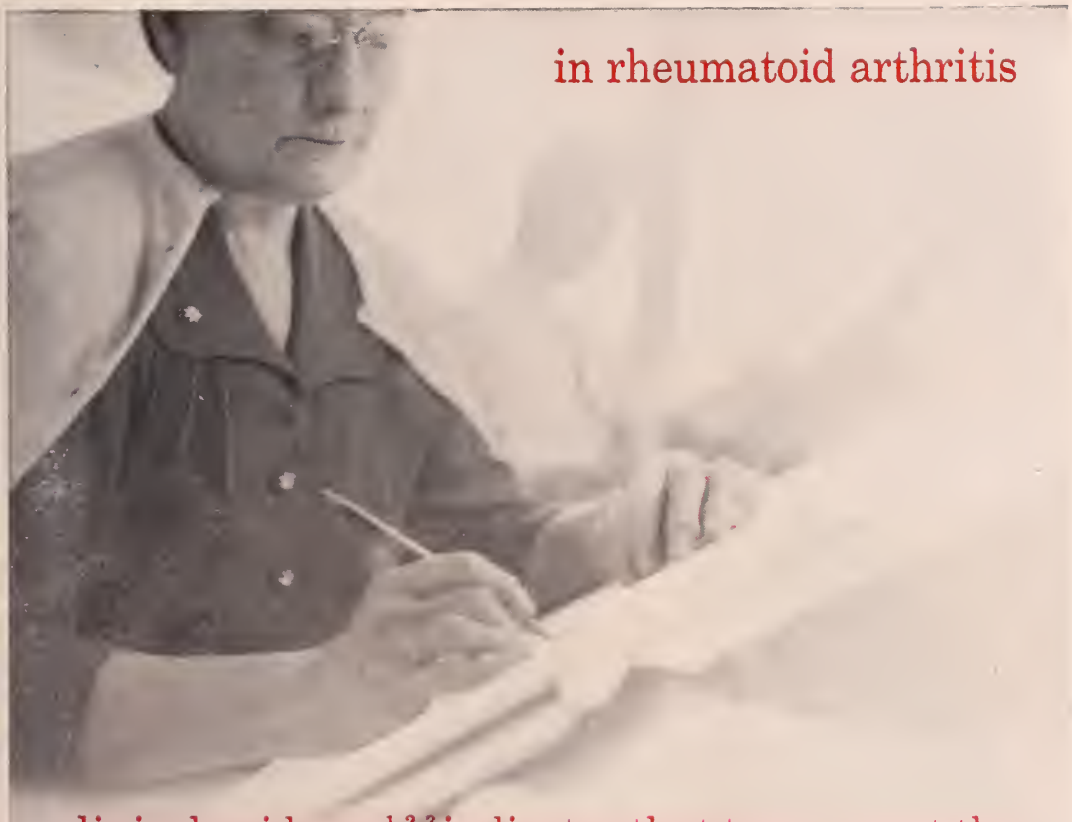
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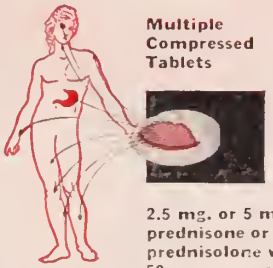
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clinical evidence[1,2,3] indicates that to augment the therapeutic advantages of the "predni-steroids" antacids should be routinely co-administered to minimize gastric distress

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Multiple Compressed Tablets

2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

'Co-Deltra'

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All the benefits of the "predni-steroids" plus positive antacid action to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613 (February 25) 1956. 2. Margolis, H. M. *et al.*, *J.A.M.A.* 158:454 (June 11) 1955. 3. Bollet, A. J. *et al.*, *J.A.M.A.* 158:459 (June 11) 1955.

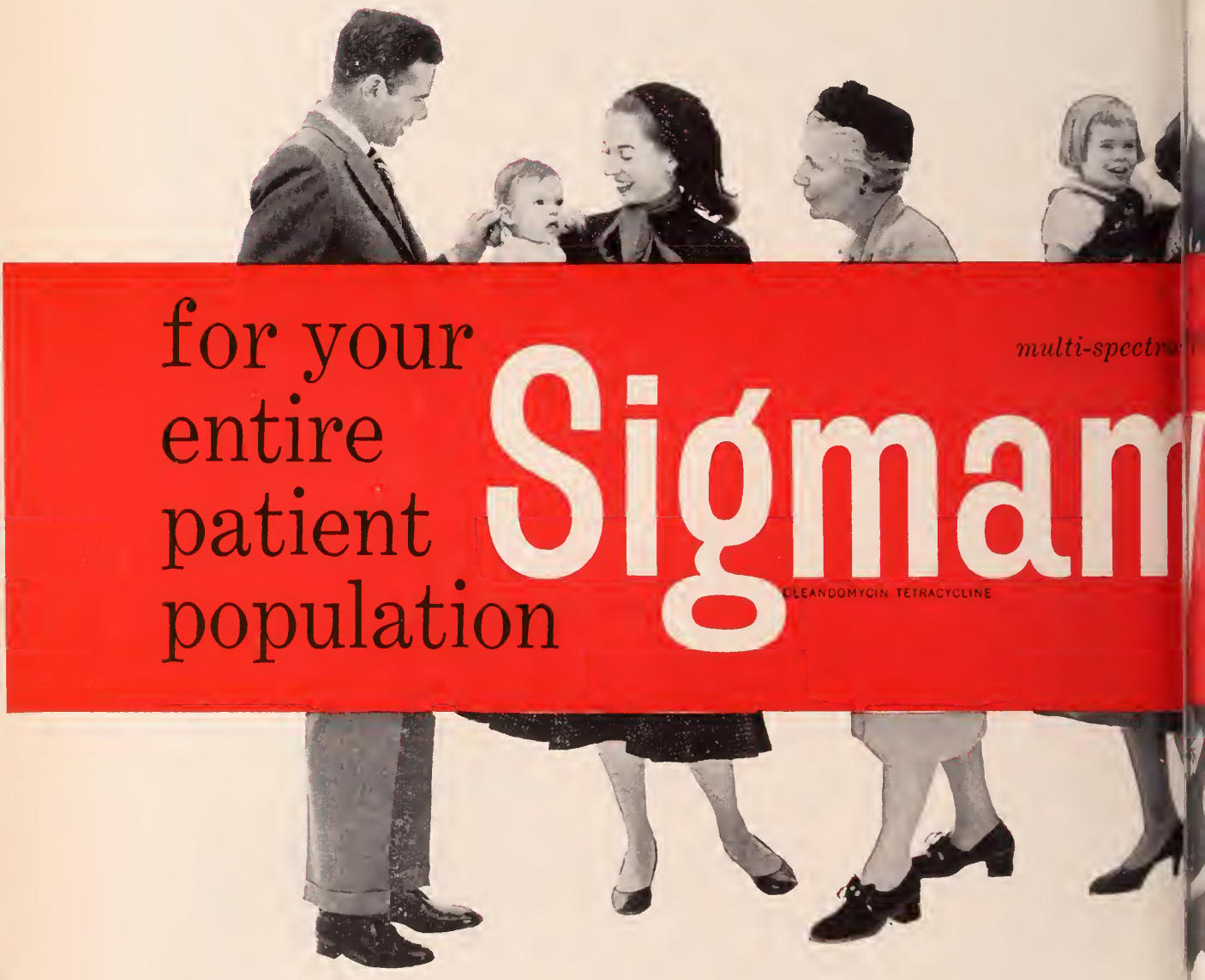
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FFECTIVE in respiratory infections
ing the 25% due to resistant
ococci.[1-3]

EFECTIVE in dermatologic and mixed
ssue infections including the 22%
nt to one or more antibiotics.[3-6]

EFFECTIVE in genitourinary infec-
ncluding the 61% resistant to other
tic therapy.[2,5]

FECTIVE in diverse infections includ-
21% due to resistant pathogens.[1,5]

EFFECTIVE in tropical infections in-
those complicated by heavy bacte-
ntamination or multiple parasitisms.[7]

1. Carter, C. H., and Maley, M. C.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 51. 2. Shalowitz, M., and Sarnoff, H. S.: Personal communication. 3. Shubin, M.: Personal communication. 4. La Caille, R. A., and Prigot, A.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 67. 5. Winton, S. S., and Cheserow, E.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 55. 6. Cornbleet, T.: Personal communication. 7. Loughlin, E. H.; Mullin, W. G.; Alcinder, L., and Joseph, A. A.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 63.

†the antimicrobial spectrum of tetracycline extended and potentiated with oleandomycin (Matromycin®) to combat resistant strains of pathogens—particularly resistant staphylococci—and to delay or prevent the emergence of new antibiotic-resistant strains.



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how bioflavonoids with ascorbic acid help in threatened and habitual abortion...

Frequent nosebleeds, gum bleeding and easy bruising were observed in a high percentage of women who had repeated abortions, according to one study.[1]

Another investigator[2] reported abnormal capillary fragility in 80% of habitual aborters.

Bioflavonoids with ascorbic acid help to diminish abnormal capillary permeability and fragility by acting to maintain the integrity of the "cement" substance of capillary walls. Thus, C.V.P. may be a helpful adjunct in the management of threatened and habitual abortion.

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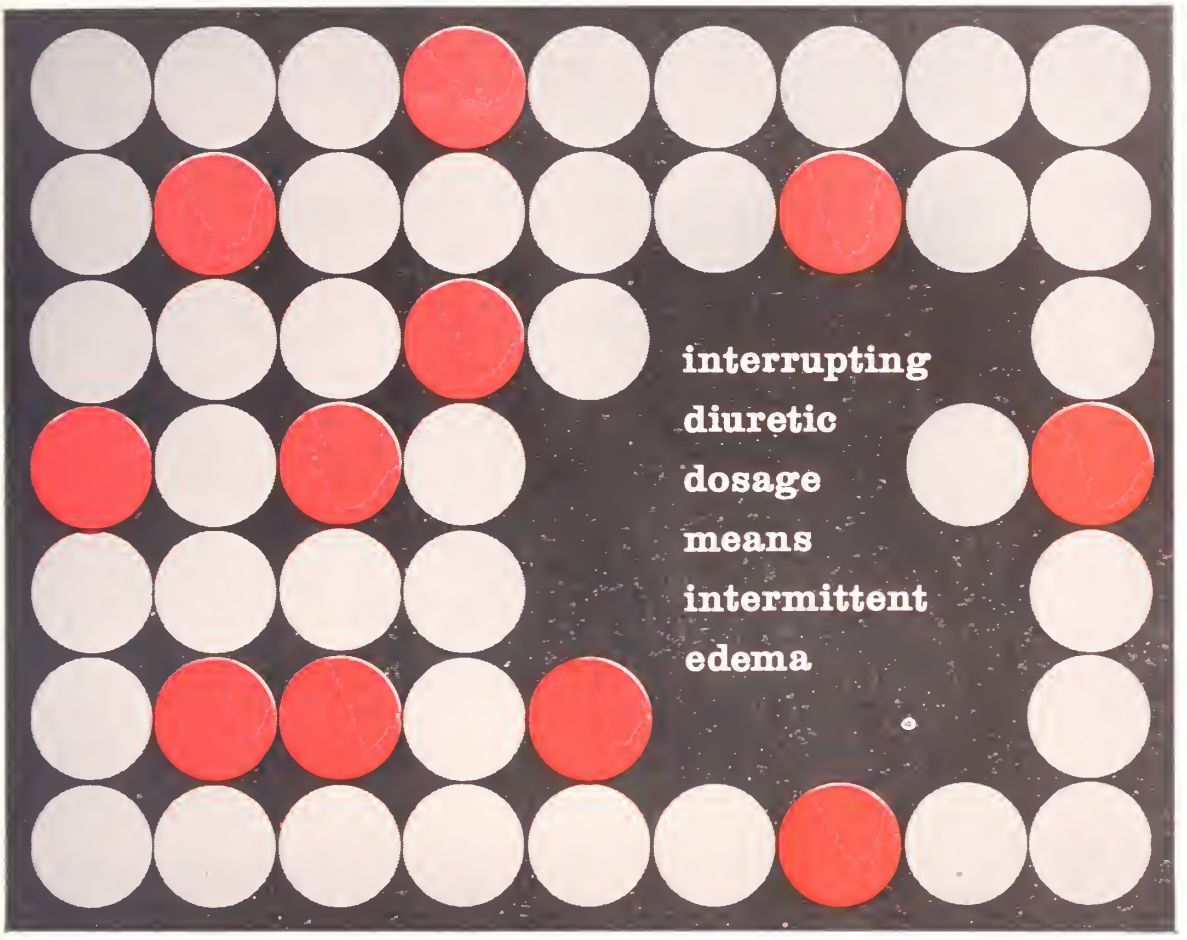
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Citrus Flavonoid Compound . . .	100 mg.
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1. Science News Letter, March 1954
2. Greenblatt, R. B.: Obstet. & Gyn. 2:530, 1953

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Riboflavin	1.0 mg.
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1. Locket, S.: Brit. M.J. *1*:809 (Apr. 2) 1955.

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2. Wright, W.T., Jr., et al.: J. Kansas M. Soc. *57*:410 (July) 1956.

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*Geiger, E.: Digestion, Absorption and Metabolism of Protein, in Wohl, M. G., and Goodhart, R. S.: Modern Nutrition in Health and Disease, Philadelphia, Lea & Febiger, 1955, pp. 98-143.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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—*with a much higher degree of safety*

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Each tablet of Pabalate-HC contains 2.5 mg. of hydrocortisone — 50% more potent than cortisone, yet not more toxic.



FORMULA

each tablet:

Hydrocortisone (alcohol)	2.5 mg.
Potassium salicylate	0.3 Gm.
Potassium para-aminobenzoate	0.3 Gm.
Ascorbic acid	50.0 mg.

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2. *Meprobamate*—the newest and safest of the muscle-relaxant tranquilizers for profound relaxation of skeletal muscle in spasm.

Tolerance to this combination is good because there is little likelihood of sodium retention, potassium depletion or gastric distress with buffered prednisolone, and meprobamate rarely produces significant side effects in therapeutic dosage.

An additional important therapeutic benefit, often overlooked, stems from the tranquilizing action of meprobamate. This component of MEPROLONE relieves mental tension and anxiety so often manifest in arthritics, making them more amenable to other rehabilitation measures.

INDICATIONS: A wide variety of conditions, in which four symptoms predominate: *a*) inflammation *b*) muscle spasm *c*) anxiety and tension *d*) discomfort and disability; i.e., rheumatoid arthritis, rheumatoid spondylitis (Marie-Strümpell disease), Still's disease, psoriatic arthritis, osteo-

Therapeutic benefits of MEPROLONE compared with traditional a

	relieves pain	suppresses inflam-mation	relaxes muscle	eases anxiety
Salicylates	✓	✓		
Muscle relaxants			✓1	
Tranquilizers				✓1
Steroids	✓	✓		
MEPROLONE	✓	✓	✓	✓

1. Meprobamate is the only tranquiliz muscle-relaxant

arthritis, bursitis, synovitis, tenosynovitis, myosit sitis, fibromyositis, neuritis, acute and chronic l pain, acute and chronic primary and secondary and torticollis, intractable asthma, respiratory allergic and inflammatory eye and skin disorders tenance therapy in disseminated lupus erythe periarteritis nodosa, dermatomyositis and sclero

SUPPLIED: Multiple Compressed Tablets in b 100 in two formulas as follows: MEPROLONE-1— of prednisolone, 200 mg. of meprobamate and 20 dried aluminum hydroxide gel. MEPROLONE-2— 2.0 mg. of prednisolone in the same formula.

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ANTIRHEUMATIC,

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THAT SIMULTANEOUSLY

RELIEVES:

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2. JOINT INFLAMMATION
3. ANXIETY AND TENSION
4. DISCOMFORT AND DISABILITY

MSD

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Erythromycin in Treating Pneumonia

A 27-year-old man, a chronic alcoholic, was admitted with a hi
tory of an alcoholic spree followed by a cough, greenish sputun
and chills and fever.

Physical examination showed a temperature of 104 F. and indicated pneumonia in the right lower lobe. This was confirmed by X-ray. The sputum revealed gram-positive diplococci and blood culture subsequently grew Type VII pneumococci.

The patient was treated with erythromycin, 300 mg. every six hours per os. His temperature dropped to normal by 18 hours and X-ray of the chest revealed considerable clearing by the fourth hospital day. After 10 days hospitalization, the patient was fit for discharge.[1]

First Antibiotics Symposium, we reported the successful treatment with
hromycin of *H. influenzae* pneumonia and bacteremia. A second patient
with *H. influenzae* pneumonia and bacteremia had a clinical course almost
identical to the one previously reported, with cure obtained by treatment with
500 mg. of erythromycin per os every four hours for 14 days.

Of these 132 patients with bacterial pneumonia, 127 (96%) had
result. One patient with

"Highly Effective in Pneumonia"

In one investigation, 75 adult patients with bacterial pneumonia were treated with erythromycin. In his summary, the clinician reported: "It is concluded that erythromycin is highly effective in the treatment of pneumonia due to gram-positive bacteria."[2]

This, of course, is only one of many reports showing the effectiveness of ERYTHROCIN against coccic infections. You'll get the same good results (nearly 100% in common, bacterial respiratory infections) when you prescribe ERYTHROCIN. Abbott

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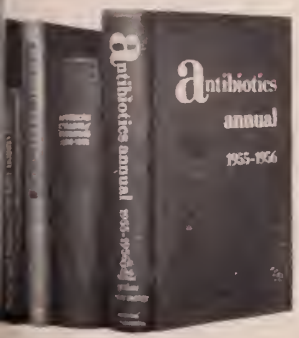
STEARATE

"No Serious Side Effects Occurred"

After a study of 171 patients treated with erythromycin, the investigator wrote: "No serious side effects occurred with prolonged therapy or with doses up to 8 Gm. per day in the severe infections."[1]

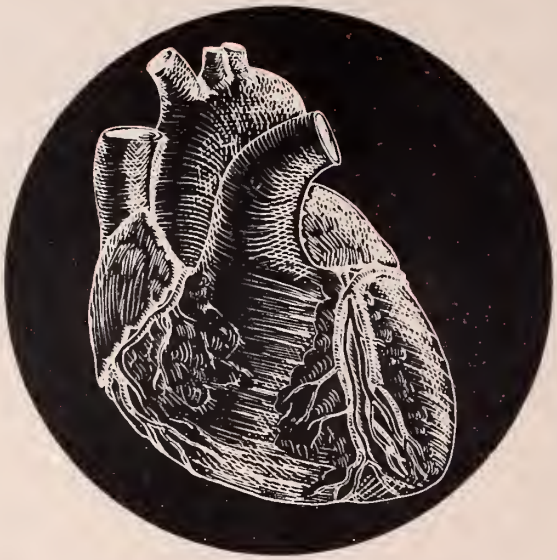
Actually, ERYTHROCIN stands on a remarkable record of safety. After four years, there's not a single report of a severe or fatal reaction attributable to erythromycin. In addition, you'll find allergic manifestations rarely occur. *Filmtab* ERYTHROCIN Stearate (100 and 250 mg.), in bottles of 25 and 100. Abbott

® Filmtab—Film-Sealed tablets, Abbott; pat. applied for.



1. Romansky, M.J., et al., Antibiotics Annual 1955-1956, p. 48,
2. Waddington, W. S., Maple, F. C., and Kirby, W. M. M., A.M.A. Archives of Internal Medicine, 1954, p. 556.

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for dependable
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Ampuls: 0.5 mg. in 2 cc.

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B—rub in
C—brush off, or rinse off if desired

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oiliness of scalp

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†'Amytal Sodium' (Amobarbital Sodium, Lilly)

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THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Marcus Ward Newcomb, M.D. 1880-1957

Among the signers of the Declaration of Independence were five physicians. It is doubtful if a state document of similar importance today would have so high a proportion of physician participants. Of the hundreds of statesmen who have served as United States Senators, 35 were M.D.s—but most of them served in the first half of our country's history. New Jersey has supplied 30 physicians to the House of Representatives—a body to which it has been sending Congressmen, every two years since 1789. Again, a disproportionate number of these physicians served in the 19th, not the 20th century. One physician — Dr. William A. Newell, was Governor of New Jersey in 1857.

Today, however, most doctors avoid this kind of public service. They brand it as "politics" or say it takes up too much time for too little reward. And so, having more or less disfranchised ourselves in this way, we complain about legislation and bureaucracy. But we don't do anything about getting in there and helping the legislators or bureaucrats.

There is one doctor, however, who cannot be thus impeached. The late Marcus Ward Newcomb was speaker of the New Jersey Assembly in 1936. Indeed, in 1935, he formed the extraordinary combination of majority leader of the house plus President of The Medical Society of New Jersey. His formal obituary appears on page 133 of this JOURNAL. This cold type, however, does not begin to picture this dynamic doctor's impact on New Jersey. It is hard for the ordinary physician to be both an individual practitioner and a civic leader. But not for the extraordinary physician: Marcus Ward Newcomb, for instance.

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Single Copies, 30 Cents

Tranquilizing: Physiologic or Pharmacologic?

Pharmaceutical houses now vie with each other to develop newer calming drugs. Soon we will have a "tranquilizer of the month" club. Since you never get something for nothing, you have to pay a price for tranquilizing drugs. Effective drugs must be potent drugs; and if a drug is "strong" it will not just stop when it has produced the desired effect. It will keep going and cause a "side effect." Chlorpromazine can produce jaundice, parkinsonism, delirium and skin reactions. Azacyclonol (Frenquel®) is not consistently effective in controlling anxiety and reserpine may cause an alarming drop in blood pressure. Meprobamate, under its trade-names of Miltown® and Equanil® have become household words, and sophisticated users are now calling them "don't give a darn" pills.

Nor is the side-effect or over-effect the only price-tag on these drugs. Tranquilizers tranquilize the physician who gives them, making it less likely that he will strive to understand the patient. Tension states do not exist in a vacuum. They are the products of emotion and they mediate through physiologic, not pharmacologic, channels. It's harder for the physician to probe the emotional background of the patient and harder for him to effect physiologic relaxation — harder to do these than to dash off a prescription. There is, for example, the whole area of the physiology of skeletal musculature contraction—once a subject of medical interest, now much neglected by us. Physiologists know that emotionally conflicted patients can reflect their problems by tensing up their peripheral muscles: this, indeed, is how the word "tension" comes to be used for emotional states. Fortunately each of us has a built-in tranquilizer—the power to relax. Physiologic relaxation can be learned . . . and taught. But it's a lot simpler just to write a prescription. And the doctor who can first learn, then teach a way of living has conferred a greater boon on the patient.

A Latter-Day Jenner

Elsewhere* in this issue is the announcement of an international prize for family physicians—an "idea or hunch concerned with the cause, diagnosis, treatment or prevention of disease. I believe that among the obscure and unassuming family doctors of the world, there may be another Jenner . . ."

We do not, these days, think of the general practitioner as a pioneer, a discoverer of the new, or even as a clinical investigator. The word "research" today conjures up the image of a chrome-plated laboratory, a million dollars' worth of equipment and a staff of technologists. Yet the gallery of the great in medicine—the doctors who really caused our science to advance by giant steps—is made up largely of family doctors. Whether you think of Banti or Bright, Laennec or Landry, Paget or Parkinson, they were all general practitioners. Necessarily so, since, prior to World War I there were indeed very few specialists in our entire profession.

We have, in the past decade, seen many plans for restoring the GP to his pedestal; graduate courses, GP sections in hospitals, the American Academy, and an annual gold medal. Odd that no one has thought of this one—of reminding the family doctor of his past glory as the man who invented the stethoscope and discovered the gonococcus; the man who found what digitalis could do, and the man who discovered how the blood circulates. Perhaps the GP himself has developed an inadequacy feeling when it comes to investigation. He is awed by the equipment of research and the emphasis on group work. True, the elaborate equipment and the teams of tech-

*See page 131.

nologists may be needed to follow through and to validate a thesis. But there is still no substitute for imagination, intellectual boldness, hard work and original thinking, when it comes to the art of discovery. Surely the modern GP is no less intelligent than his professional sires, though he may be less confident of research skills. What the GP had been doing for centuries before this one, he can do again.

Electricity is Life: Electricity is Death

The old ones among us remember those penny-in-the-slot machines that gave you a tingling little electric shock. "Electricity is Life" the sign said. And indeed it is. The extracellular fluid pool of the body is electrolytic. The heart, the brain and all functioning organs generate electric currents. And if the body is a source of electricity, it is also a recipient of it. The ancients applied electric eels to the forehead for the relief of migraine. In 1775 one Dr. James Graham devised an electrified bed, and rented space in it for 50 British pounds a night. Dr. Graham advertised that in his bed, "the joys of the marriage union are intensified because performed under the glowing, accelerating and genial influences of the heaven-born, all-animating element, electricity!" Electricity has been medically used since it first became usable in any form.

Electricity has always gripped the human imagination. The glamor and the magic that once surrounded the word "electric" is now transferred to the adjective "electronic."

No one can now practice medicine without electricity. It lights up our scopes, operates our x-rays, and is inherent in the various "grams" and "graphs" by which we record physiologic function. Hardly anyone would know what to do next in a hospital that suddenly lost its electrical supply. In physical medicine, electricity is king. It is used directly as a therapeutic modality; and indirectly it is indispensable since it operates the machinery of most of the other physiotherapeutic modalities. The surgeon depends on it for cautery and for operating room lights. The internist uses electricity in the electrocardiogram and the fluoroscope. The pathologist would be overwhelmed in an hour if he could not use electricity. Medicine's newest branch—radiophysics and isotope medicine—has no history that antedates electricity. And so, in varying degree, it goes with every specialty of medicine and surgery.

Electricity is life. And electricity is death. In half our states (including our own and all adjacent to us), electricity is the instrument for putting to death a doomed felon. Electricity can, and does, cause accidental death. And electricity is indispensable in mass deaths produced by modern bombing, modern artillery, or any aspect of modern war.

Yet electricity can save one from death. It is a dramatic therapy for barbiturate poisoning. And it has a high batting average in lifting patients out of suicidal depressions, and thus in warding off self-induced death. In this respect, electricity is a mystery. No one knows how it works. H. L. Gordon in the November 1948 *Military Surgeon* listed 50 theories seriously advanced to explain the effectiveness of electro-convulsive therapy in depressions. If 50 reasons can be given, no reason is known. Indeed, it is not even known whether the convulsion as such is the valuable element of ECT, or whether it is the electricity passing through the brain or whether it is the loss of consciousness.

In a battery, the basic unit of electrical operation is called a "cell"— the same word that describes the basic operating unit of life. The biologic cell is also an electrical cell.

The sweet mystery of life may be love, and love we are told makes the world go round. A more accurate, even if less gallant thesis would be that what makes the world go round is an electromotive force. If ever it is given us to fashion a key that will fit the lock that guards the mystery of life, that key will surely be an electrical—or electronic one. *Omnis cellula e cellula* said Rudolf Virchow in 1858. For the twentieth century, the slogan must be "All life is electricity."

GENE L. D'ALESSANDRO, M.D.
ROLF VLATTEN, M.D.

Newark

Trichlorethylene in Obstetrics*

Self-administered trichlorethylene appears to approximate the ideal desiderata for obstetrical analgesia. Routine narcotics make only a third of the women in labor "comfortable." With trichlorethylene, the score was 92 per cent.

THE relief of pain during labor has been a problem with which obstetricians, anesthesiologists and pharmacologists have been long concerned. The problem is complicated by the fact that we are dealing with two patients: the mother and the unborn child. What is good for one may be bad for the other. Infants depressed by medication given for the relief of labor pain are made worse by obstetrical trauma.[1] It is incorrect to assume that every failure of the infant to breathe spontaneously is the result of the administration of anesthetic drugs. Anesthesia and analgesia have made possible modern obstetrical practices which have reduced the incidence of stillborn due to trauma. However, heavy sedation and depressing anesthetic agents have had a tendency to offset this gain.

Therefore, we continue our search for the ideal agent for the relief of pain during labor. This agent should have the following features:[1]

1. Completely relieve mother's pain during labor.
2. Preserve her cooperation.
3. Preserve the whole reflex mechanism of bearing down in the second stage.
4. Preserve uterine contractibility and tone.
5. Have no depressing effect on the infant.

Early reports suggest that trichlorethylene comes closest to fulfilling these prerequisites. Therefore, we undertook a study of trichlorethylene for the relief of pain during labor. This drug was first used as an anesthetic agent in human beings[2] in the United States[3] in 1934. In 1936 the Council on Pharmacy and Chemistry of the American Medical Association[4] reported that the evidence did not then justify acceptance of trichlorethylene for general anesthesia. It asked for more investigation of the toxicity of decomposition products. The second deterrent to its widespread use in America came in 1943 when Waters and his group[5] published an analysis of the cardiac arrhythmias with trichlorethylene. They concluded that the drug could cause undesirable effects on the automaticity of the heart. This

*This work is from the Newark (N. J.) Presbyterian Hospital, Anesthesiology Department. Dr. D'Alessandro is Director of that Department.

1. Gordon, R. A. and Morton, M. V.: *Anesthesiology*, 12:680 (Nov. 1951)

2. Jackson, D. E. and Herzberg: *Anesthesia and Analg.*, 13:198 (Oct.) 1934

3. Striker, C., Goldblatt, S., Wann, I. S. and Jackson, D. E.: *Anesth. & Analgesia*, 14:68 (April) 1935

4. Use of Trichlorethylene for General Anesthesia, Preliminary Report of Council on Pharmacy and Chemistry, J.A.M.A. 107:1302 (Oct. 17) 1936

5. Waters, R. M., Orth, O. S. and Gillespie, N. A.: *Anesthesiology*, 4:1 (Jan.) 1943

statement from such an influential center is still a damper on the use of trichlorethylene in North America.

In England, the use of trichlorethylene was first reported in 1941 by Hewer.[6] Since then it has been widely used and several million patients have been anesthetized with it.

CHEMISTRY

Trichlorethylene is a colorless liquid, with a boiling point of 87 C. The British product is colored with Waxoline Blue® to distinguish it from chloroform. A trace of thymol is added as a preservative. This product is chemically pure in contradistinction to commercial trichlorethylene. If trichlorethylene is exposed to air and sunlight for more than three to four days, it will oxidize with the production of dichloracetyl chloride and phosgene. Structurally, trichlorethylene is simply ethylene with each of three hydrogen atoms replaced with a chlorine atom. In its properties, however, it resembles chloroform more than ethylene. Its anesthetic potency is on a par with, or perhaps greater than that of chloroform. To produce surgical narcosis, trichlorethylene requires a concentration of from 0.5 to 1¼ per cent in the inhaled atmosphere. The drug is not eliminated entirely through the lungs but is broken down to innocuous trichlor-acetic acid, which is excreted in the urine.

PHARMACOLOGY

Trichlorethylene was originally thought to exert peripheral analgesic effect on the trigeminal nerve but Krantz's work [7] indicates that the pain relieving property may be central in action at the level of the basal ganglia. The outstanding characteristic of this compound in clinical anesthesia is the analgesia which it produces. Its narcotic property is not great but it provides potent analgesia.

Side effects are not elicited if analgesia alone is provided. A frequent complication is tachypnea from too high a concentration. This is overcome by decreasing the concentration.[8] Its effect on the cardiovascular system is one of increased vagal tone,[9] producing a bradycardia and cardiac arrhythmias. This again occurs mainly in its use for anesthesia and not for analgesia.

There is no significant change in metabolism with the use of this drug. Two important points should be stressed:

1. *Trichlorethylene must never be used in a closed system with soda lime. There is a chemical reaction between these two substances with the production of dichloracetylene which is toxic to the nervous system.*

2. *It is a non-inflammable agent and may be used with safety in the presence of cautery.*

CASE MATERIAL

IN THIS study we examined 173 patients who had had trichlorethylene as analgesia during labor. Fifty-one of these patients were primiparas and 122 were multiparas. Seventy patients studied in a control series, received the conventional obstetrical analgesia medications which consists of primarily morphine, meperidine† or Pantopon®, with or without scopalamine. In this group we examined twenty-two primiparas and forty-eight multiparas. The ratio of primiparas and multiparas in both groups was comparatively equal. The patients were visited and questioned 24 to 48 hours after delivery.

RESULTS

ALL patients were asked about the pain relief during labor and were classified. Ninety-two per cent of those receiving trichlorethylene stated that they had complete relief from pain or felt comfortable during the entire labor period.

Comparison with the control series shows that only 30 per cent of the patients in the control series experienced complete relief from pain or felt comfortable despite more frequent doses of narcotics.

One hundred and one (101) patients of

†The meperidine was given under the Winthrop-Stearns tradename of Demerol®.

6. Hewer, C. L.: British Medical Journal, 1:924 (June 21) 1941

7. Krantz, J. C., Carr, C. J., Musser, R. and Horne, W. G.: J. Pharmacology & Exper. Therapy., 54:327 (July) 1935

8. Whitteridge, D. and Bulbring, E.: British Bulletin of Medicine, 4:85 (April) 1946.

9. Hunter, A. R.: Lancet 1:308 (March 4) 1944

the trichlorethylene series had trichlorethylene as the only medication during labor. Sixty required one additional medication. This medication was morphine, Demerol® or Pantopon® with or without scopalamine. Only twelve of the 173 patients required 2 or 3 additional medications with the trichlorethylene inhalation. Since in the control series 74 per cent of all patients had narcotics during labor, the 42 per cent of patients requiring additional medication compare favorably in the trichlorethylene series.

There was no significant difference in the relief of pain experienced by the primiparas and multiparas in the trichlorethylene series. In both of these groups over 90 per cent of the patients had a comfortable labor period.

Complications and side effects with the use of trichlorethylene were few. Only 6.4 per cent of the patients complained of nausea and vomiting; and 5.8 per cent had transitory postpartum headaches. These results as well as the condition of the newborns compare favorably with the control series.

Ninety-one per cent of the infants cried immediately after delivery; 6.4 per cent within 2 minutes. Two per cent required oxygen or resuscitation. There were no stillborns in this series. The results of the control series suggest the higher dosage of narcotics may be responsible for the comparatively larger number of lethargic and depressed babies.

We requested, in this investigation, that the patients evaluate the labor management as far as pain relief was concerned. This evaluation was definitely more favorable in the trichlorethylene series with only 18.5 per cent of the patients being more or less dissatisfied with pain management while 67 per cent of the control series were not satisfied with the relief received from the usual labor analgesia alone. There was no difference in the patient evaluation between primiparas and multiparas.

CONCLUSIONS

1. Trichlorethylene inhalation was self-administered for analgesia in 173 patients. Ninety-two per cent of the patients were comfortable.

2. A comparison of the patients that were comfortable in the trichlorethylene and control series shows that 92 per cent were comfortable with trichlorethylene while only 30 per cent were comfortable with the routine medication. The trichlorethylene analgesic effect showed no significant difference between the medicated group and the non-medicated group.

3. Both primiparas and multiparas were comfortable in over 90 per cent of all trichlorethylene cases. No significant difference in relief between primiparas and multiparas.

4. The distribution of cases between primiparas and multiparas in both the trichlorethylene series and the control series is approximately the same.

5. Of the trichlorethylene patients, 81 per cent considered the management of labor as good or excellent. In the controlled series only 32 per cent of the patients considered the management of labor as good or excellent.

6. Both primiparas and multiparas evaluated trichlorethylene as excellent or good in over 80 per cent. No difference in patient evaluation between primiparas and multiparas.

7. The complications and side effects with trichlorethylene were minimal.

The Newark Presbyterian Hospital

We thank Dr. George Matheke and Dr. Lloyd M. Felmly for the use of their patients in this study.

Louis F. Raymond, M.D.
Rowland Goodman, II, M.D.
East Orange

Lipocaic Factors in Arteriosclerotic Choroiditis*

In a Case of High Myopia

Choroiditis in an arteriosclerotic patient responded to ACTH and lipocaic factors. The eye pathology was reversed by this regime. The general cardiovascular status also improved.

Classification of choroiditis is extremely difficult since the clinical features are so varied. Generally, the etiology of inflammatory choroiditis falls into three main groups:

1. Exogenous, following penetrating wounds, perforating ulcers, intraocular parasites, and certain chemical, animal, or vegetable poisonings.

2. By extension of the inflammation from adjacent ocular or orbital tissues, such as uveitis due to toxic or allergic intra-ocular products which may be due to neoplasms, lens protein (endophthalmitis anaphylactica), detached retina, uveal pigment and so on.

3. Endogenous, due to organismal metastases, allergy or toxins; granulomata; as in tuberculosis, syphilis, and leprosy; virus and fungus infections; certain metabolic disturbances, *e.g.* rheumatic states, gout, diabetes, nephritis, and intoxication from the colon.

Berens[1] says that diseases of the vascular system (such as hyperemia, erythremia, leukemia, chloroma, and arteriosclerosis), may produce choroiditis. Berens and Sorsby[5] agree that choroiditis may affect the vessels of the choroid, particularly the arteries, the walls of which become considerably thickened. In some areas the lumen of a vessel is occluded and, later, hyaline degeneration takes place in the tunica media. It is evident that the nutrition of the outer layers of the retina will suffer, leading to degenerative changes in the layer of rods and cones and subsequent atrophy of the retina and optic nerve. Patches of pigment appear in the retina, the pigment having passed from the retinal pigment epithelium through gaps in the external limiting membrane, and, eventually, the vision deteriorates.[2] Gifford[3] reasons that inflammatory choroiditis has the same basic etiology as iridocyclitis, syphilis, tuberculosis, and focal infection.

Adler[4] describes inflammation of the choroid as due to circulatory stasis; it is especially vulnerable to emboli and an accumulation of serum, cells and bacteria. He also points out that due to the rich anastomosis of blood vessels, such emboli do not affect a large portion of the choroid, but remain fairly well isolated. The end result is a dissemination of small foci or inflammation throughout the choroid to give a clinical picture of disseminated choroiditis. The vitreous is invaded by leukocytes and serum to cause fine dust-like vitreous opacities. These may clump together and cause stringy, thread-like opacities. The retina will show edema and later absorption of the pigment epithelium in the affected area. The first ophthalmoscopic appearance of a choroiditis,

*Read by invitation May 14, 1956 before the Staff of the East Orange General Hospital.

therefore, is edema of the retina with white or gray areas of exudate.

Arteriolosclerosis in the choroid, as in the spleen, is a normal phenomenon appearing in the early forties and progressing slowly, irrespective of vascular sclerosis elsewhere.[5]

Tassman[6] states that advanced age, with general sclerosis and gradual impairment of nutrition, is accompanied by degenerative changes in the eye, and lists these changes as being due to circulatory and metabolic diseases. He adds that optic changes may result from an interference in the blood supply due to the abnormalities present in other organs, or from a systemic disease primarily affecting the blood vessels themselves, causing degenerative changes in the eye. These changes depend on the severity and the duration of the underlying impairment. He classifies chronic forms separately which include the granulomata such as syphilis and tuberculosis. Tassman also states[7] that degeneration of the choroid occurs as the result of nearly all inflammatory conditions affecting the retina and choroid.

THE most common type of arteriosclerosis is atherosclerosis. This degenerative vascular disease is characterized by localized lipoid deposits in the arterial intima. During the early stage of atheroma development, these appear as small, round or oval, slightly elevated, yellowish-white, glistening and opaque thickenings of the intima. They especially involve the posterior aspects of the aorta, and, particularly, the lower edges of the orifices of the intercostal arteries, and the spurs of bifurcations of large arteries. These curved and narrowed stretches are sites where, for normal or pathologic reasons, the smooth and continued flow of blood is interfered with. As these lesions grow, they become thick cushions which may coalesce and finally involve larger parts of the arterial wall. During more advanced stages hyaline, calcific and fibrotic changes occur within the intimal atheromas, while atrophic, degenerative, and calcific alterations may develop in the media beneath and adjacent to them. Interference with the circulation of the blood results from the reduction of the arterial lumens by the protruding atherosclerotic lesions, from the impairment of the functional resilience and contractility of the vascular walls by the intimal and medial fibrotic and calcific changes, and from their liability to thrombotic complications.

Although atherosclerosis is found most often in persons of middle and advanced age, it is not necessarily the result of a physiologic aging process. Atherosclerosis in its uncomplicated form has been observed during recent years in an increasing number of young patients. It has also been found[8] as a complicating factor in hypertonic-hypertensive arteriosclerosis.

CASE REPORT

A 51-year old woman was hospitalized on November 3, 1952. Her complaints were dizzy spells and blurred vision. For the past three months her vision with correction was: right eye, finger count 12 feet; left eye, finger count seven feet. External examination of the eyes was negative. Refraction was O. D. -14.00; O. S. -16.00. The media were hazy. A diagnosis of active choroiditis was established. She had atrial fibrillation. Extra-systoles of ventricular origin and myocardial ischemia were demonstrated by electrocardiogram. X-rays of the heart and lungs showed no abnormalities except for scoliosis of the spine. Sedimentation rate was 40 millimeters per hour upon admission. Cholesterol was 370.

Other symptoms were: low back pain which (believed to be caused by a herniated intervertebral disc) radiated pains along the back of both legs, and pain and numbness in both hands.

Therapy consisted of intravenous adrenocorticotrophic hormone (A.C.T.H.), 40 units daily, administered over eight hours, supplementary vitamins (Theragran®†), lipocaic factors (Litrison®†), and potassium chloride. On the sixth day, the ocular media began to clear. On the seventh day there was marked clearing of the ocular media with pigmentation, showing an arrest of the choroiditis. Pains in the extremities and the back were now relieved for the first time. Several days prior to discharge, she was started on cortisone. A.C.T.H. was discontinued at the same time. A second electrocardiogram on the day prior to discharge (six days after start of treatment) showed entirely normal findings. Sedimentation rate was now only 5. She was asymptomatic with clearing of the vision upon discharge from the hospital, twelve days after admission.

†Squibb & Co., New York, New York and Hoffmann-La Roche, Nutley, New Jersey respectively.

Follow-up office treatment consisted of continued cortisone acetate orally with potassium chloride plus vitamins and lipocaic factors (Litrison®). Vision improved to: right eye, 20/40; left eye, 20/50 with best correction on January 23, 1953. The back, arm and leg symptoms were relieved as the vision improved. Vitamins and lipocaic factors were discontinued. The patient was treated with cortisone only: 100 milligrams in divided doses, plus potassium chloride.

Three weeks after all supportive vitamins and lipocaic factors were discontinued, the vision with best correction was reduced to 20/70 in both eyes, and the symptoms of the arms, legs and back returned. Vitamins and lipocaic factors were reinstituted. A fortnight later, cortisone and potassium chloride were gradually discontinued. Vitamins and lipocaic factors were continued. Two weeks after this, she was asymptomatic and the vision again improved to: right eye 20/40, left eye, 20/50 with best correction.

On advice of friends, the patient discontinued all therapy and changed her environment. This vacation terminated on June 2, 1953. After three months, during which time the patient received no medication or vitamins, her original symptoms of dizzy spells, poor vision, back, leg and arm pains returned. Best corrected vision was 20/400 in either eye.

New therapy consisted of cortisone, potassium chloride, and lipocaic factors (Covitral®).* Only gradual improvement was present until August 20, 1953. Corrected vision improved to 20/60 in each eye. The other symptoms also were relieved. Thyroid with Vitamin C 300 milligrams daily were added.

On September 14, 1953, lipocaic factors were gradually reduced and the patient was given Vitamin C, thyroid, and vitamins (Theragran®). Choroiditis with small hemorrhages was present and vision reduced gradually. The blood cholesterol was 362 milligrams per cent.

On July 12, 1954, vision with best correction was 20/400 in either eye. Vitamins and thyroid were discontinued. Litrison® capsules, nine daily, were started in divided doses. The patient improved until September 9, 1954. Lipocaic factors were gradually reduced again, and finally discontinued.

On October 4, 1954, four weeks later, the corrected vision was 20/400 in each eye and all the previously mentioned symptoms had returned. Lipocaic (Chothyn® and Litrison®) were again started in large doses. Corrected vision improved to 20/60 in each eye, the patient was asymptomatic in two weeks. On October 21, 1954, the lipocaic dose was reduced. Chothyn® was discontinued and the patient has remained asymptomatic on Litrison® only, nine capsules daily since October 28, 1954.

One year later, she reported she had no symptoms, her corrected vision was 20/60 in each eye. In May, 1956, the patient reported no physical symptoms and vision has remained good. Lipocaic therapy has been maintained regularly, dose: six capsules daily.

A case of retinal arteriolosclerosis in a middle-aged woman with high myopia is presented. The presenting complaints were related to the eye. On hospitalization, physical findings were arteriosclerotic heart disease, and similar vascular changes in both extremities which responded to therapy. The choroiditis responded simultaneouly with the general improvement.

Treatment of the choroiditis was according to Gordon's recommendation, using intravenous A.C.T.H. Supplementary vitamins and lipocaic factors were added as supportive therapy. Symptoms returned upon the patient's discontinuance of therapy. Similarly no relief was obtained while she was kept on maintenance doses of cortisone, Vitamin C, and thyroid.

Lipocaic factors, in large doses, reversed the eye pathology and the general cardiovascular status on several occasions with ophthalmoscopic evidence of arrested choroiditis coinciding with the relief of general symptoms.

THE high vitamin intake plus the lipocaic factors seemed to be responsible for the benefits observed in this patient although the A.C.T.H. and cortisone may have been responsible for the initial rapid response observed by reducing the intensity of the inflammatory response.

Clinical control of the patient on lipocaic factors alone (Litrison®), after four years with no remissions, is illustrated by this case.

It is generally considered that arteriosclerotic changes are beyond help. Nutritional studies, proved by liver biopsy, show this is not true. The changes occurring in the livers of choline-deficient humans as well as experimental animals have been the subject of study for years.[9] Severe kidney damage is known to develop in weanling rats when the diet is deficient in choline. Arterial damage occurring in rats maintained on a choline-deficient diet was reported by Best.[10]

Stetten and his co-workers[11] reported that the feeding of ethyl laurate to young rats re-

*Flint, Eaton—Decatur, Illinois.

ceiving no choline resulted in death from heart failure in three to six days. High concentrations of ethyl laurate in the diet—35 to 40 percent—were required to produce the effect, and the latter was not induced by the ethyl esters of other fatty acids. The pathologic process was described as an acute diffuse interstitial myocarditis.

THESE observations have now been confirmed and extended by Wilgram and Hartroft.[12] They performed detailed histopathologic and histochemical studies of the hearts of rats fed choline-deficient diets containing 25 to 40 per cent of fat, and demonstrated either fatty or necrotic changes, or both, in the heart of almost every animal. This phenomenon was observed not only with ethyl laurate, but also with trilaurin, tricaproin, and lard. Supplementation of the diets with choline prevented the development of the cardiac changes except for slight abnormalities in a few animals. When coconut oil was used as the fat component of the choline-deficient diet, the hearts and kidneys of rats remained essentially normal, although the livers were very fatty.

Heller showed choline to be a stimulant of phagocytic velocity in the reticuloendothelial system, and in this manner assist in detoxification. Heller also described various agencies known to depress reticuloendothelial system activity.[13] Among these are: (1) whole body radiation, and (2) the administration of cortisone.

Chevremont[14] pointed out that, of the many substances tested, choline was the only compound that stimulated histiocyte formation in tissue culture. Smulders[15] showed later that the injection of choline would increase the number of phagocytes in the livers of frogs.

Upon the basis of such findings, Heller tried choline as a physiologic mechanism for effecting stimulation of reticuloendothelial system activity in mammals. He pointed out that cortisone depressed the activity of the reticuloendothelial system cells.[16] as measured by their phagocytic activity and their regenerative capacity before and after cortisone administration. In contrast, choline stimulates the reticuloendothelial system. Vitamin B_{12} also exerts a stimulative effect similar to, but somewhat less effective than, choline.[17]

Thomas[18] indicates that the increase in mortality from agents such as bacteria, fungi, viruses and toxins in cortisone-treated animals and man might be due to a depression of the reticuloendothelial system. Choline, Vitamin B_{12}, or both, may be expected to overcome this effect through stimulation of the reticuloendothelial system.

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A bibliography of 18 citations appears in the authors' reprints

Cardiac Overdiagnosis

Organic heart disease was confirmed in only 26 per cent of Philadelphia school children initially suspected of cardiac disease.† They participated in a program of secondary screening of cardiac suspects conducted by Drs. Sidney Friedman and C. Robert E. Wells. Reexamination resulted in the transfer of 108 cases from the categories of rheumatic fever, innocent murmur and miscellaneous to that of organic heart disease and of 966 children from the category of questionable or real heart disease to that of no heart disease.

These findings demonstrated that "cardiac disease has been overdiagnosed in the course of the initial routine physical examinations," the investigators said.

†Friedman, S., and Wells, C. R.: The Journal of Pediatrics 49:410 (Oct.) 1956.

Harold A. Kazmann, M.D.

Long Branch

Gall Bladder Disease*

Many doctors are impaled on the horns of the "surgical versus medical" dilemma when deciding what to do about gall bladder patients. Dr. Kazmann, however, has no doubts: the surgical approach, he feels, is the method of choice for all gall bladder disease except chronic cholecystitis without stones.

Diseases of few organs or systems respond as completely and satisfactorily to correct surgical therapy as do those of the biliary system. Most patients on whom biliary surgery is indicated, can be relieved of symptoms and restored to health, with the liver and bile ducts capable of functioning adequately, for normal physiologic comfort and longevity.

Nonsurgical treatment of symptomatic gall bladder disease has little to offer. Restrictive diets may lessen the frequency of "colic" or minimize "dyspepsia." Medication can diminish the pain of acute attacks. Conservative therapy can aid in recovery from such episodes. However, no medical treatment can "dissolve" gall stones in the gall bladder, or return a diseased bladder to a normal state. Delay in surgery often permits a disease which had been confined to the gall bladder (and which could have been completely "cured") to involve other structures, where the disease presents a greater hazard, and where operative treatment cannot offer as high an incidence of good results. Yet such delay is common. The fault lies partly with the patient, who usually is not urged to be operated on during an acute attack. He feels so well between attacks that he hopes that there will be no recurrences. Delay may also be due to the physician who does not urge operation and does not stress the hazards of delay. Perhaps the patient or the doctor knows of a case in which biliary tract surgery failed to relieve symptoms. Thus he may hesitate to accept surgery. An understanding by the profession of the causes of poor results of biliary surgery, and diligence in avoiding them will allow proper surgical therapy of symptomatic cholelithiasis to assume its proper place.

Surgery has little to offer the patient with chronic cholecystitis without stones. On the other hand, *any gall stone* (with or without symptoms) *warrants surgical treatment.*

Symptoms in gall bladder disease are produced by infection, by the maintenance of high intraductal pressure either due to common duct stone or spasm of the sphincter of Oddi, and by stones obstructing the cystic duct, and the building up of pressure within the gall bladder. Many victims of cholelithiasis have lost not only the function of the gall bladder, but also the tone of the sphincter of Oddi. This sphincter, if properly functioning, permits free flow of bile into the intestine and minimizes digestive disturbances of biliary origin.

*Read by invitation to the medical staff of the Rip Van Winkle Clinic at Hudson, N. Y. on September 6, 1956. This work is from the Surgical Department of the Monmouth Memorial Hospital.

Small stones usually produce severe colic when they try to pass through the cystic duct. Large stones, particularly solitary ones, may be too big to pass through the cystic duct. When they become lodged in the neck of the gall bladder, they often produce rapidly developing and serious complications—like acute cholecystitis, gangrene of the gall bladder, or necrosis and perforation of its wall. The stone may erode into any hollow viscus and cause a spontaneous internal biliary fistula, through which the stone may pass distally until an intestinal obstruction is produced.

Complications of gall bladder disease are:

1. Infection following obstruction of cystic duct. (Acute cholecystitis and occasionally cholangitis, gangrene, rupture, and abscess.)

2. Infarction and/or obstructive symptoms following stone in the common duct. These symptoms include cholangitis, jaundice, liver abscess and that curious intermittent hepatic fever that used to be called "Charcot's fever."

3. Biliary fistulae, internal or external.

4. Carcinoma. Carcinoma without stones is exquisitely rare. At least 90 per cent, possibly 98 per cent, of all biliary carcinomata, are in patients who have gall stones.

THE mortality of early gall bladder removal, in the patient under fifty who has stones, symptomatic or not, is probably 1 to 2 per cent. In older patients with metabolic, circulatory, nephritic or hepatic disease, the danger is greater and the mortality much greater.

If our medical philosophy is to emphasize prevention and prophylaxis, then we must give most serious consideration to calculus gall bladder disease as a surgical problem and treat it on that basis. Here are some popular misconceptions about gall bladder disease.

1. *Cholelithiasis occurs predominantly in women who are "fat, fair, forty, fertile, flatulent."*

Symptoms of gall bladder disease usually begin in early adulthood rather than in middle life, especially in women who have borne children. Gallstone colic often occurs in slender women younger than 30 years of age shortly after parturition. In the late decades, the relative incidence of gall bladder disease among men and women is approximately the same.

2. *In individuals harboring gall stones, dietary indiscretion is the principal factor in precipitation of attacks of colic.*

Dietary factors produce "indigestion" and flatulence and may be factors in inducing attacks of colic; but no such association can be demonstrated in many cases. Emotional disturbances may be an inciting influence. The tendency for many attacks to start during sleep suggests a postural factor. In other cases acute cholecystitis develops during an unrelated illness, or after an operation or delivery.

3. *A single large gall stone is less dangerous than multiple small ones.*

The mortality rate and incidence of major complications is higher with single stones than with multiple stones. Cholecystoenteric fistulas and gall stones ileus are most frequently associated with a large stone than with multiple stones.

4. *Stone in the common bile duct causes jaundice.*

Jaundice is *not* noted in about one-third of cases of proved common duct stones. Prediction cannot be made before operation as to whether exploration of the common bile duct will be required.

5. *Exploration of the common duct adds little to the morbidity with cholecystectomy.*

Almost without exception, analysis of gall bladder operations by different surgeons discloses a significant rise in morbidity and mortality when exploration of the common duct is added to simple cholecystectomy. The hazard of indiscriminate exploration of the common duct deserves emphasis. The best safeguard against common duct involvement is early operation.

6. *Acute cholecystitis is accompanied by fever and leukocytosis.*

Blood counts and temperatures are normal in over 20 per cent. Acute cholecystitis may even progress to gangrene without significant fever or leukocytosis.

7. *Perforation of the gall bladder is rare.*

Perforation occurs in 5 to 10 per cent of individuals with acute cholecystitis treated conservatively.

8. *Quiescent gall stones may safely be left alone.*

Cancer of the gall bladder develops in 5 per cent of persons with gall stones. Apart from the hazard of cancer, the initial gall stone attacks may be severe and complicated or come at an unfavorable time, as after an unrelated operation, or delivery. The physician's decision to recommend nonoperative treatment subjects the patient to an over-all risk, disproportionate to the risk of a cholecystectomy for the otherwise healthy.

9. *Patients may be safely relieved of attacks of gall stones colic by opiates, permitting a cholecystectomy at an elective time.*

Caution is necessary; a patient so treated may assume that an operation not necessary during previous episodes is not necessary later and so postpone surgery until a more serious complication develops.

10. *Gall stones become less dangerous as the patient attains a more advanced age.*

Operative mortality rates are distinctly higher for elderly patients.

A survey of surgical patients over 70 years old ranked biliary tract disease next to repair of hernia in frequency, and next to carcinoma of the stomach and colon in mortality. Complications are common and perforation occurs more often than with younger persons. Obviously, an elective cholecystectomy in the middle age is less hazardous than an urgent cholecystectomy later.

255 Third Avenue

Poison*

Ordinary, everyday sense makes us see to it that poison labels are kept pasted on the bottles of dangerous chemicals on the shelves of our medicine closet. Iodine, for instance, although an excellent disinfectant, would be the death of a child who took a drink of it. Such labels must be renewed, if they fade, or become unreadable.

In the same way a constant repetition is needed of the label "Poison" on all forms of mass-prejudice, racial injustices, making an individual suffer for something he doesn't do, or is not, because some of his group have done it or been it. They are all poisons—some slow and insinuating and gradual; some lightning-swift like a rattlesnake's bite. And every variety, slow or swift, mildly sickening or quickly fatal, should be labeled in our minds, "poison," so that we recognize it as dangerous the instant we see or hear it.

When we see somebody incautiously step out towards a piece of ice on a sidewalk, on which we have seen others slip and fall, we shout to him "Look out! *Danger!*" We should train ourselves to have the same reaction of shocked alarm when we hear somebody voice one of those horridly mild-sounding conversational expressions of prejudice: 'Well, he's this or that. What would you expect?"

Civilized people have advanced so far in understanding as to feel discomfort on hearing such phrases. But the discomfort is not yet great enough, in most cases, to match the discomfort of answering boldly in a good loud voice, "Such talk is dangerous. Words like that grease the slide, down which it is mighty easy to slip to iniquitous acts." We just get tired of the necessary repetition of the warnings against racial discrimination. We have the cheering hope that they may not be always needed. A good many warnings of the past can be laid aside, because we have outgrown the practices they labeled as dangerous.

We can get rid forever of all this talk about resisting racial discrimination—by stopping it. When American citizens, men and women, are judged not by the group to which they belong, but by their individual personalities, and admitted on this same obviously American principle to theaters, hotels, schools, hospitals, colleges and the like, we can stop this tiresome hammer-hammer-hammer on the theme that unjust exclusion of one is poison for us all.

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*This item, by Dorothy Canfield Fisher, is published in the interest of Brotherhood Week.

Carl P. Guzzo, M.D.

Orange

Acute Pancreatitis

In 1955 the Harrison Martland Award of the New Jersey Anatomic and Pathologic Society was won by Dr. Carl P. Guzzo for a 14,000 word monograph on the development and diseases of the pancreas. This paper is one section of that prize essay.

Acute pancreatitis occurs as a pancreatic edema or as an acute pancreatic necrosis. The most plausible etiologic theory is that a common channel exists between the terminal bile and pancreatic ducts. Here the reflux of bile into the pancreatic duct causes bile salts to activate the pancreatic ferments and they escape into the surrounding tissue. (Opie [1]) Some say that only infected bile can cause the disease. Rich and Duff [2] suggest that it is necessary to inject the bile into the pancreatic system under sufficient pressure to rupture the ducts.

Pancreatitis may occur from the blood as by trauma. The pathology varies considerably. Diffierent phases of the disease may occur in different parts of the gland. In *pancreatic edema,* the gland is swollen, indurated and pale. The overlying peritoneum may be elevated by interstitial fluid and the lobulations of the gland may appear more prominent than normally. If the process is extreme, but has not advanced to hemorrhagic necrosis, the vessels are engorged and the gland appears red and acutely inflamed. Microscopic sections show interstitial edema with accumulation of inflammatory cells, but with preservation of parenchymal architecture.

Isolated areas or the entire gland may be involved with varying degrees of hemorrhagic necrosis. The gland appears irregularly enlarged and firm. In the areas of hemorrhagic necrosis the gland is purplish or black. The continuity of the gland may be completely disrupted. A large slough may thus be present, which can be separated from the main pancreatic mass. The necrosis is not necessarily confluent, and is frequently spotted with areas of normal tissue. Zones of liquefaction and cystic degeneration are common. Repair may be seen.

Areas of fat necrosis may be observed in and around the pancreas. They may reach as far as the mediastinum, lipase being carried to these areas *via* the lymphatics. These areas of fat necrosis appear opaque, chalky, and are a few millimeters in diameter.

Microscopic areas of thrombosis in the arteries and veins are seen with necrosis of vessel walls. Varying degrees of autolysis with complete destruction of acinar tissue can be seen adjacent to the areas of interstitial edema, hemorrhagic exudate and cellular degeneration. Zones of necrosis are surrounded by inflammatory reaction, characterized by the accumulation of poly's, rbc. Ductal dilatation and metaplasia may be seen.

SYMPTOMS

Acute pancreatitis may affect any age. Most victims of this disease are in the midde age bracket. The symptoms in edema differ from the symptoms in necrosis.

In acute pancreatic edema, symptoms are mild and vague. The symptoms of acute necrosis, on the other hand, are violent and more specific. Although the milder form is more common, one can better appreciate the manifestation of pancreatitis by studying the acute necrotic form. The onset is sudden and violent, with pain, nausea, vomiting and abdominal distention. The pain originates in the epigastrium. It is persistent and progressive. It may be sharp, lancing, boring or explosive. A constant, unyielding quality frequently extending to the back and upper left quadrant, is aggravated by food and water. An average dose of morphine does not help. Soon after the pain, nausea and vomiting appear. These are persistent and prolonged. The vomitus consists primarily of gastric contents and bile. The act of vomiting which frequently relieves the pain of biliary colic does not help here.

SIGNS

TENDERNESS is noted in the epigastrium or upper abdomen. The tenderness gradually increases and becomes more diffuse as the disease progresses. Muscle spasm and rigidity may occur but are rarely extreme.

Tenderness in the flank and in the left costovertebral angle is common. The abdomen becomes silent as the disease progresses. Segmental ileus occurs with the small bowel or large bowel—"sentinel loop" and Cavitch's sign respectively. Low blood pressure, rapid pulse, cyanosis and collapse are seen only in severe cases. Pre-clinical shock (as manifested by hemoconcentration and decrease in blood volume) is common. Mild jaundice is seen in 25 per cent of the cases. This may be due to obstruction of the common duct by edema of the head or by a stone in the ampulla of Vater; or it may be the result of hepatitis.

Temperature elevation in acute pancreatitis is moderate. The patient's temperature varies from 100 to 103 degrees except at the late stages when suppuration may occur. In about 15 per cent of cases, there is an abdominal mass palpable in the epigastrium on the fifth or sixth day. It is a tender mass, irregular in outline and gradually increases in size over a period of several days.

Cullen's and Grey-Turner's sign is discoloration of the umbilical area and flanks respectively. This occurs in 10 per cent of severe and late cases on the third or fourth day. Warren's sign is edema of the flanks seen by inspection and felt by palpatation. This may appear early.

LABORATORY FINDINGS

THERE is a moderate leucocytosis hemoconcentration and increase in serum amylase levels. Lipase is elevated. These levels are at their peak in 24 to 48 hours. Then they gradually decline. It takes the lipase level a little longer to fall, but this test is more difficult to do. Hyperglycemia and glycosuria are noted. The patient may develop a diabetes mellitus. Saponification of fats causes a decrease in available serum calcium. This hypocalcemia occurs on the sixth or seventh day. According to Edmundon,[3] values below 7 milligrams per hundred cubic centimeter are of grave prognostic import.

A segmental ileus may be visualized on x-ray.

DIFFERENTIAL DIAGNOSIS

THE practitioner must consider and rule out: cholecystitis, perforated ulcer, mesenteric thrombosis, coronary occlusion and/or intestinal obstruction. Severity of pain and unresponsiveness to morphine suggest acute pancreatitis. Radiation of the pain to the back and left upper quadrant and left flank points to the pancreas. Discrepancy between severity of symptoms and paucity of physical findings may help. Later, shock, cyanosis, abdominal distention and presence of an epigastric mass confirms the diagnosis. The elevation of the amylase and lipase helps establish the diagnosis.

Complications include pancreatic cysts, pancreatic abscess, pancreaticolithiasis, massive hemorrhage, diabetes mellitus, internal and external fistula and hypocalcemia.

TREATMENT

Most patients with edema of the pancreas survive. With necrosis of the pancreas, the mortality is high. Prior to the adoption of delayed operations in the treatment of acute pancreatitis, the mortality was 50 per cent. With delayed operation, it is 15 per cent.

Conservative delayed operation is preferred. To relieve pain, use meperidine.* Morphine may cause a spasm of the sphincter of Oddi. Atropine, nitroglycerine or amyl nitrite may be helpful in less severe cases. Procaine block of the sympathetic nerves in the upper lumbar ganglions may help. Continuous epidural analgesia is useful.

Restore water and electrolytes. Use antibiotics to prevent infection. A Miller-Abbott tube is needed to prevent ileus.

Ephedrine or methantheline (Banthine®-Searle) suppresses the secretion of the pancreas. Replace insulin and calcium. The doctor also seeks to detect and eliminate pancreatic cysts and abscesses.

Operation should be done if the diagnosis is questionable, and for patients in whom cysts or abscesses occur.

If early operation is done because of a mistake in diagnosis, little manipulation is in order. Biliary tract distention or stones should be removed. Decompression is done by cholecystectomy or choledochostomy. The pancreas should not be incised or otherwise manipulated early in the course of the disease. If secondary suppuration occurs, the necrotic areas should be removed and suction drainage instituted.

Suppurative pancreatitis usually secondary to acute pancreatic necrosis, is characterized by fever, leucocytosis, epigastric tenderness, induration and edema of the flank, occasional jaundice, glycosuria, and a palpable mass. Treatment is incision and drainage of the abscess in the necrotic area. Occasionally, pancreatic abscesses may point into the flank and if feasible should be drained without entering the peritoneal cavity.

*Trade-named as "Demerol" (Winthrop-Stearns).

CASE REPORT

A 49-year old man was admitted because of attacks of upper abdominal pain, about 3 hours after a heavy meal. The pain was epigastric, substernal, excruciating, and associated with dyspnea, cyanosis and perspiration. This attack persisted 6 hours and then stopped. A month later he developed sudden severe pain in the epigastrium three hours after eating. This was associated with dyspnea. Pain persisted unabated after three injections of morphine. He had nausea and no vomiting. His blood sugar was 206 milligrams, serum amylase was over 300 Somogy units. Conservative treatment was pursued and he enjoyed some relief of pain. However, he had lassitude and a low grade fever. Studies a week later revealed epigastric fullness and a questionable mass in epigastric area. Serum amylase was then 587 units. At operation, an abscess of the pancreas was found. Treatment, as outlined above, was successful.

258 Reock Street

Glycyrrhiza in Peptic Ulcer

An analysis of 195 case histories of gastric or duodenal ulcer treated with glycyrrhiza compound and antacids showed clinical benefit in 179 cases (92 per cent) and x-ray improvement in 160 of 186 roentgenologically studied cases. Results in ambulatory cases were almost as satisfactory as for bed patients. The advantages of this treatment were prompt relief of the symptoms in less than a week, relief of spasm as well as of gastric hyperacidity, and roentgenological healing of the ulcer niches in most cases. The tablets contain glycyrrhiza extract of standardized glycyrrhizin content compounded with light magnesium carbonate, bismuth subnitrate and sodium bicarbonate as antacids, plus small amounts of frangula and calamus to offset the constipating effects of bismuth. Apparently glycyrrhiza relieves gastroduodenal spasm and thereby contributes to the natural healing of gastric and duodenal ulcers.

—Ant. M.: New York Physician, 47:1 (November) 1956.

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Butabarbital-Mephenesin Synergism*

Clinical Study of 32 Chronic Psychiatric Patients

Are you weary of wonderful reports from new wonder drugs? Here is a paper which says that 72 per cent of the patients were not helped: a refreshing change from the more usual proclamation of panacea.

The present phase in the development of psychiatric progress will probably be regarded as "the era of tranquilizing drugs."

The rauwolfia drugs, chlorpromazine, meprobamate, and others, have rapidly burgeoned but no panacea has been developed. Nor is it proposed that the drug here presented is such a panacea. It is, however, one additional attack to the several already available. In certain chronic psychoneurotics and ambulatory psychotics, it appears to be efficacious.

In clinical research on any new drug we encounter pitfalls which lead to erroneous results. In almost every instance this error is towards overoptimistic reports. The enthusiasm of the investigator may lead him (we hope—unconsciously) to see improvement where none exists. The excitement in the clinic is contagious. Patients cognizant that "new" drugs or procedures are being used respond often more hopefully than realistically and will report subjective improvement.

All this is followed too often by the denouement: the patients find the medication no longer helps; more objective studies fail to corroborate the happy findings, and the tested drug or procedure shrinks to its proper place in therapy, not infrequently to a well deserved oblivion.[1]

CASE MATERIAL

The criterion for selection of outpatients in this research project was the traditional "one inch chart," *i.e.* we used only those patients whose clinic record was an inch or more in thickness. Most of them had been to over ten clinics, some to over twenty clinics (*i.e.* departments — medicine, dermatology, etc.).

*The synergistic drug, a mephenesin-butabarbital combination is tradenamed Halabar®. It was supplied to use by the manufacturer, E. W. Carnrick Company of Newark.

1. A statement on tranquilizing drugs. Committee on Research, American Psychiatric Association, Washington, D. C.

Most of them had been known to the psychiatric clinic for over five years, some for as long as twenty years. All had run the gamut of psychiatric attacks. Nothing had availed. All carried diagnosis of either severe psychoneurosis or ambulatory psychosis. This group would certainly constitute an acid test for any therapeutic measure.

Seventy patients were started on the study but only thirty-two continued with sufficient constancy to warrant inclusion in any appraisal. With the behavior we anticipate in patients with such diagnoses, many started with the placebo and then failed to return. Several reported immediate relief on taking the placebo. Others on placebos complained of such untoward effects as burning of head, upset stomach, medicine too strong, etc., that they were dropped. Two deaths from antecedent disease (heart, diabetes) also occurred. No deaths or untoward reactions from the medication were encountered. Those who failed to complete the prescribed course of therapy will be the subject of another communication (the desire to remain sick?). A neurotic is fond of his symptoms and may become anxious if he sees them disappearing, or if he sees them attacked.

A check list was made which included the principal symptoms, but certainly not all of the symptoms, complained of by our patients.

METHOD

ALL patients started on placebo medication. Several immediately reported that they felt improved. Even with chronic psychiatric patients, the power of positive psychotherapy should never be gainsaid. These patients were continued through the study. If they did not relapse into manifesting further symptoms it was felt that they must be discounted from our evaluation.

The second pills given to the patients were mephenesin, then butabarbital, followed by the combination of the two (Halabar®) and lastly, phenobarbital. Some of these patients had been on "maintenance" phenobarbital for years.

In testing this compound drug,* the following technic was used: Pills identical in color and size were supplied of the following: (a) placebo, (b) butabarbital, (c) mephenesin, (d) Halabar® (a combination of butabarbital and mephenesin)* and ½ grain phenobarbital tablets.

The patients were informed that they could partake of this experiment if they so desired. It was explained to them that some of these medications would be potent, others valueless, but they would not know which medicines they were using. The therapists did not know what medications they were dispensing. They knew them only by code symbols.

The patient was given enough pills to take one four times a day for three weeks. He returned to the clinic every three weeks. There his subjective complaints and appraisals were recorded. During this period all other therapy was discontinued. The therapists were requested to give as little psychotherapy as was necessary to keep the patient from withdrawing from the project. Each patient served as his own control.

The appraisal was made more by the patient than by the investigator. While this technic may be subject to some criticism we feel that it meets pragmatic criteria.

PHARMACOLOGY

AN EXTENSIVE bibliography exists on the drugs mephenesin and butabarbital. In combination, they seem to produce some synergistic effects, making therapy more potent than either of them alone.

Butabarbital is both hypnotic and sedative. It shows initial effects in about 30 minutes and its action is sustained for 5 to 8 hours. It is rapidly destroyed, and is excreted in the urine when too much is given. It is essentially nontoxic to the liver, and is not contraindicated in renal disease.[2] Butabarbital rates extremely

2. New and Non-Official Remedies. Council on Pharmacy & Chemistry, Phila. Lippincott, 1954.

3. Exley, K. A.: Autonomic Ganglion Depressant Properties of Barbiturates. *Nature*, London: 170:242 (1952).

high in sympathetic ganglion transmission suppression.[3]

Barbiturates of medium action range have been repeatedly described[4] as preferable in treatment of simple insomnia, agitation due to reactive responses (difficult situations), functional gastro-intestinal disease, psychoneurosis and so forth.

Dripps[5] feels that butabarbital compares favorably with or surpasses phenobarbital in the production of mild prolonged sedation, that it is of greatest use in the field of daytime sedation.

The mild, relatively prolonged action of the drug makes it suitable for many functional disorders and for the treatment of the "nervous tension" and anxiety associated with certain organic diseases such as hyperthyroidism, peptic ulcer, hypertension, spastic colon and ulcerative colitis.[6] Anxiety states in older age groups appeared to respond well to small doses of the sedative.

Mephenesin, if given in conjunction with barbiturates has some unusual modifying actions. The initial excitement produced by some barbiturates is suppressed, yet small amounts injected with ineffective doses of barbiturate produce narcosis of considerable duration and ineffective doses of mephenesin with anesthetic doses increases depth and duration of anesthesia (Berger).[7]

Experimental work shows that mephenesin decreases the muscle tension associated with recognizing mental and emotionally charged moods.[8]

CLINICAL USES

IN 1948 Schlesinger *et al.*,[9] employed mephenesin with psychotherapy and reported that "the effect was at least as efficient as hypnotic doses of barbiturates and had the advantage of permitting the attending physician to deal with a conscious patient in full command of his protective reflexes."

In 1949 Schlan and Unna,[10] said "it promises to be helpful as an adjunct to psychotherapy," and they found it alleviated anxiety in some cases.

Dixon *et al.*,[11] in 1950, used it in alleviating some anxiety "tension states." Stungo,[12] in 1950, found it also exerted an effect in the psychic sphere, the therapeutic response obtained in cases of anxiety and depression being very marked. Paul,[13] in 1952, described mephenesin as among the few drugs which relieve anxiety-tension symptoms without hypnotic effects.

RESULTS

IN THREE patients the results were little short of astounding. The first of these, a 32-year old housewife, had been attending the Newark Beth Israel Hospital Clinic since May, 1953 with intractable headaches, insomnia, nervousness, and some depression. Under the placebo medication all of her symptoms continued and she added thereto nightmares. Mephenesin alone produced "some improvement." On butabarbital alone, the patient regressed to her previous state, on the combination of the two (Halabar®), the patient reported that she felt much better, no longer had headaches, and enjoyed good restful sleep. On phenobarbital her symptoms recurred. She was placed on maintenance Halabar.® She continues symptom free as of last report. She was carried with a diag-

4a. Salter, William T.: A Textbook of Pharmacology. Philadelphia, Saunders (1952).

4b. Clark, A. J.: Applied Pharmacology. Ed. 8. London, Churchill (1952).

5. Dripps, Robert D.: Selective Utilization of Barbiturates. J.A.M.A., 140:212 (Jan. 15) 1949.

6. Physicians Desk Reference to Pharmaceutical Specialties and Biologicals. Oradell, N. J., *Medical Economics*, 1954.

7. Berger, F. M., Lynes, T. E.: The Effect of Mephenesin on Barbiturate Anesthesia. Arch. Int. Pharmacodyn. (August) 1955.

8. Dickes, Robert, *et al.*: Effect of Mephenesin on Muscle Tension. Archives of Psychiatry and Neurology, 74:590 (Dec.) 1955.

9. Schlesinger, E., *et al.*: Am. J. Med., 4:365 (1948).

10. Schlan, L. S. and Unna, K. R.: Some Effects of Myanesin in Psychiatric Patients. J.A.M.A., 140:672 (April 1) 1949.

11. Dixon, H., *et al.*: Handling Anxiety States. Am. J. Med. 220:23 (1950).

12. Stungo, E.: Mephenesin in Psychiatric Conditions. Lancet, 2:931 (1950).

13. Paul, L.: Mephenesin in Anxiety States. Psychosomatic Medicine 14:378 (1952).

nosis of psychoneurosis, anxiety type with conversion phenomena.

A 62-year old woman had been a patient at our Neuropsychiatric Clinic since March 1951. She ran a complete gamut of signs and symptoms; dizziness, headaches, precordial pain, obesity, positive Mazzini (successfully treated), insomnia, arthralgic pains in the right shoulder, left hip, osteoarthritis of the right knee, arthritis of the spine, hyperopia, absentmindedness, and then an episode of sudden loss of fifty pounds with vaginal bleeding, followed by dilatation and curettage. In the clinic she was described as having labile emotional responses. The picture was one of psychoneurosis, mixed type. She responded excellently to the medication. On the Halabar® she felt greatly relieved, retaining the sole complaint of burning of the scalp. On phenobarbital, her general symptom complex returned, her headaches recurred, she stated that her eye became bloodshot, and she requested being replaced on the previous medicine, the Halabar®.

A 50-year old housewife had been a patient in the Newark Beth Israel Hospital Clinic since May 19, 1947. Her complaints throughout the years consisted of itching, generalized aching of the body, dyspnea, flushes, irregular menses, headaches, nervousness, nocturia, frequency, burning, rectal bleeding and backaches. She was alternately diagnosed as "pseudoneurotic schizophrenia" and as "catatonic schizophrenia." There was no improvement with medication until the patient reached the Halabar®. She stated that this made her feel "somewhat better." From this patient, this must be considered high praise in view of her constant carping querulousness! She relapsed when the phenobarbital was tried, and again improved on the test medication.

These three were patients on whom exceptionally good results were obtained. They also give a concept of the type of patient on whom the study was carried out.

Six other patients seemed to have obtained some benefit from Halabar®, and appeared to prefer it to other medications, appeared to have some lessening of complaints both qualitatively and quantitatively. These six we feel definitely improved.

On the other 23 patients we did not obtain any appreciable constant results.

APPRAISAL

NINE of the 32 patients appeared to have obtained some benefit from this combined medication. This is an improvement ratio of 28 per cent. The patients were particularly recalcitrant to therapy. The medication was not enhanced by other treatment. This certainly suggests that the drug warrants further trial and probable inclusion in therapeutic attack on the chronic psychiatric patient.

82 Clinton Avenue

Is Atropine an Antispasmodic?*

Antispasmodic activity is improperly attributed to atropine and related compounds. The term suggests the replacement of excessive and uncoordinated movements with tranquil, rhythmic motility. What is achieved by these drugs is rather the quantitative reduction of all motility and secretion, without alteration of its basic pattern. This is due to the site of action of these drugs—at the post-ganglionic cholinergic nerve-ending rather than at the integrating centers in the brain.

*Almy, T. P.: American Journal of Digestive Diseases, 1:238 (May) 1956

Maxwell Malament, M.D.

East Orange

Prostatic Carcinoma*

One of the commonest malignancies in males is cancer of the prostate. With sky-rocketing of our "over-65" population, this may well become one of the top medical-surgical problems of the 1960's. Here is a compact discussion of diagnosis and management.

People are living longer because of medical and industrial progress. We thus have more and more elderly people in our population. In this country, in 1950, there were 152 million people. Of these, only 8 per cent were more than 65 years old. This figure will rise to 14 per cent by the year 2000. The total population, it is forecast, will rise by 30 per cent. Persons over the age of 65 will increase by 200 per cent!

A disturbing element presented by the aging male is the rising rate of cancer of the prostate. Already, in the male, this has outstripped the incidence of cancer of the stomach and intestines. The National Office of Vital Statistics report that 38 per cent of prostate cancer deaths occur within the ages of 65 to 74 years and 34 per cent between the ages of 75 and 84 years; thus over 82 per cent of all prostate cancer deaths occur after 65 years of age.

This paper deals with cases of carcinoma of the prostate observed in the Veterans Administration Hospital at East Orange.

OCCULT CARCINOMA

In evaluating statistics one must differentiate between occult and clinical carcinoma. Occult carcinoma or *carcinoma in situ*, is a malignant lesion usually found on microscopic examination of the enucleated or resected prostate gland for an apparently benign hypertrophy. The lesion is an isolated island of early neoplastic changes and is completely surrounded by the benign hyperplastic tissue. It may appear as a single or multiple focus in the gland. There is no evidence of local spread of the tumor. Roentgen, as well as chemistry studies, are normal. Occult carcinoma of the prostate is found in 14 per cent of all resected and autopsy specimens. Greene and Simon[1] reported that 4 per cent of a series of 2090 prostate neoplasms were of the occult type. In this hospital the incidence has been 6 per cent.

Occult carcinoma may lay dormant for many years. What initiates its growth is unknown. The favored theory is, that since it coincides with the decline of active sex life, the neoplastic changes are the result of an imbalance of the sex hormones. Many urologists prefer none or only conservative therapeutic measures since the 5 year survival rate is 70 per cent. However, clinical carcinoma may become evident in a small proportion of these, and therefore other urologists recommend follow-up

*The work is from the Urologic Section of the Veterans Administration Hospital in East Orange. Dr. Malament read this paper to the Essex County Medical Society in Newark, N. J. on November 8, 1956.

1. Greene, L. F. and Simon, H. B.: Journal of the American Medical Association, 158:1494 (March 1955)

radical surgery. When the *carcinoma in situ* initiates local invasive growth it is then considered a clinical type of carcinoma. The growth is slow, silent, and disseminates metastases late. When clinical symptoms appear, the gland is usually inoperable; only 5 per cent being amenable to surgery at this stage.

CLINICAL CARCINOMA

ABOUT 20 per cent of all males will develop symptoms of prostatic obstruction. Some 14 per cent of these (that is, 2.8 per cent of all males) will show neoplastic involvement.

Routine autopsies have revealed carcinoma of the prostate in 14 per cent of the males; and after the age of 65 years the incidence increases to 20 to 37 per cent. In this hospital, 298 cases of prostatism were admitted in a 4 year period. Sixty-five cases demonstrated malignant changes, an incidence of 21 per cent.

Carcinoma of the prostate arises, in 80 per cent of the cases, in the posterior lobe of the gland. This is a flat lamellal strip of tissue lying posterior and caudal to the median lobe. The posterior lobe is not removed by the routine enucleation of transurethral resection of the prostate gland. This explains the appearance of carcinoma after surgery for benign prostatic hypertrophy in 6 to 12 per cent of the reported cases. In this hospital 9 per cent had previous surgery, with the resected specimens showing no evidence of any malignant change. These patients returned with recurrent symptoms and cancer 1 to 10 years after surgery.

The early malignant prostate usually presents no clinical symptoms. Early lesions suitable for radical surgery are diagnosed on routine physical examination, on annual checkups, or when admitted for some other disease. It may be a co-existing nodule with benign hypertrophy; the latter causing the clinical symptoms of obstruction. When symptoms due to the malignancy occur, growth has extended beyond the capsule with probable dissemination of metastases. These symptoms are similar to that of hyperplasia of the prostate gland and are manifested by frequency, nocturia, hesitancy, dysuria and occasionally gross hematuria. The local urinary symptoms are most frequent and were present in 60 per cent of our cases. These symptoms existed for three months to three years prior to the diagnosis. Other symptoms of this cancer are due to the metastases. Hip pain, usually unilateral, radiating down the thigh, and low back pain were present in 30 per cent of our cases. This high incidence of a symptom not related to the urinary tract, but due to metastases to the spine and local pelvic extension, is a noteworthy sign. *Cancer of the prostate gland should be considered in the differential diagnosis when unilateral hip pain or low back pain is a dominant symptom in males over* 50 *years of age*. Generalized weakness and weight loss were present in 6 per cent. No symptoms were present in 4 per cent of our cases.

METASTASIS

SPREAD of the prostatic neoplasm may be by local extension, by the lymphatic, or by the hematogenous route. Lymphatic extension proceeds along the perineural lymphatics to the seminal vesicles. The local growth may extend beyond the capsule and engulf the adjacent lower ureters causing upper urinary tract obstruction. The rectum is rarely invaded. The Denonvilliers fascia (which separates the prostate from the rectum) acts as a protective barrier. The tumor may extend into the bladder cavity and is usually the cause of gross hematuria. The lymph nodes along the iliac vessels can become enlarged with tumor cells and pressure on the soft walled adjacent veins will produce stasis and edema of the lower extremity. Every organ can be involved in hematogenous dissemination, the most frequent being the bony pelvis and spine.

DIAGNOSIS

THE most reliable method of diagnosis is rectal palpation of the prostate gland, which is 80 per cent accurate. Rectal examination is

the simplest method of diagnosis. Many doctors hesitate to submit the patient to this, as it might be embarrassing. Some physicians just dislike doing rectal examinations. However, that is the only method of diagnosis for early carcinoma, excluding the incidental finding in a surgical specimen. The early lesion is a hard isolated slightly elevated nodule. Occasionally the area may be palpated below the surface of the capsule, but presents a hard consistency as compared to the rest of the gland. The lesion at this stage is suitable for radical surgery and a possible cure. The advanced tumor reveals on palpation an enlarged, stony hard gland with an irregular nodular surface. The gland is fixed and often extends to the seminal vesicles. This type of tumor is inoperable, even if no distant metastases are demonstrated. Conservative therapy may afford temporary relief. There is no hope of cure. Hard nodules in the prostate may be caused by prostatic calculi or local fibrosis of a chronic prostatitis.

EVERY suspicious nodule should have the benefit of corroborative studies. Biopsy tissue from the prostate gland is most desirable and may be obtained by needle perineal biopsy, transurethral biopsy, transrectal biopsy or open perineal biopsy.

Needle biopsy has been found to be from 50 to 65 per cent accurate. However, with the use of the Veneema biopsy punch we have obtained positive specimens in 90 per cent of the suspected cases. We have been less successful with the Silverman needle. There have been no complications, although urethral tissue has been found in several specimens. Transurethral biopsy is also used. However, since most early lesions are in the posterior lobe, results are not completely satisfactory. In an advanced tumor, transurethral resection will usually provide positive specimens. During the past year Grabstald [2] has advocated the transrectal approach. The anal sphincter is dilated and a small incision is made through the anterior rectal wall directly over the suspected nodule, which is then biopsied. The author [2] says that this is a less formidable procedure than open perineal biopsy. Open perineal biopsy is certainly a major procedure but it is the most accurate method of excising the suspected nodule. If the frozen section is carcinogenic then the surgeon is usually prepared to proceed with radical surgery.

Roentgenograms are important diagnostic aids when metastases are present. The bony pelvis and spine are the most frequent sites of metastases occurring in 68 per cent of our cases. These lesions are osteoblastic in appearance and must be differentiated from Paget's disease. Osteoblastic metastases may also appear with breast, thyroid and bronchogenic neoplasms. The malignant prostate may on rare occasions disperse osteolytic lesions.

THE second most common finding on roentgenograms (occurring in 17 per cent of our cases) is unilateral or bilateral hydronephrosis. This is caused by the extrinsic constriction by tumor tissue of the lower ureter, where it crosses the seminal vesicles and results in a slow progressive obstruction of the upper urinary tract. Roentgenograms may show pulmonary involvement which was present in 6 per cent of our cases.

The epithelial cells of the prostate gland are known to secrete a measurable quantity of acid phosphatase. When the neoplastic growth extends beyond the capsule, an excessive amount of acid phosphatase may be produced. *Elevated serum acid phosphatase above normal limits is a definite indication of cancer of the prostate.* A normal report does not rule out the presence of cancer, since 65 per cent of cases with evident metastases have an elevated serum acid phosphatase. In the absence of metastases the serum acid phosphatase may be elevated in only 20 per cent of the cases. Another aid in the diagnosis of carcinoma of the prostate is a cytologic study of the secretion obtained by prostate massage. This is reliable only in the hands of an ex-

2. Grabstald, H. and Elliott, J.: Journal of the American Medical Association, 153:563 (October 1953)

perienced cytologist. Bone marrow specimens may likewise reveal malignant cells.

MANAGEMENT

Carcinoma of the prostate can be "cured" only by radical surgery. This includes complete excision of the prostate with its capsule, the ampulla of the vas deferens and the seminal vesicles. This has been reported as possible in only 5 per cent of all cases of carcinoma of the prostate. Jewett [3] at Johns Hopkins has been able to perform this procedure in only 19 per cent of his cases and Kimbrough [4] at Walter Reed Hospital, has stated that 70 per cent of his were eligible for radical surgery. This has been possible since in Kimbrough's series, all Army personnel over 40 years of age submit to an annual physical examination where the rectal examination is required.

Radical surgery is indicated when the neoplasm has not extended beyond the capsule, where the prostate gland is not fixed, the serum acid phosphatase is normal and roentgenograms show no evidence of metastases. Radical surgery is done by the perineal or retropubic route or a combination of both. The age and medical condition of the patient must be taken into consideration. The average life span of the male is 68 years. Life expectancy at 75 years is an additional 8.4 years. At 80 years the life expectancy is 6.3 years. Therefore, most urologists limit their surgical cases not beyond 75 or 80 years. However, each case varies and occasionally the aged patient appears to be well preserved. Radical surgery may then be undertaken in these patients who are over 80 years old.

Huggins [5] demonstrated the sensitivity of prostatic cancer cells to estrogenic hormones. By the use of female hormones and castration (to reduce the circulating androgens) it is often possible to prolong life and alleviate the obstructive and painful symptoms. The estrogens cause vacuolization and necrosis of the malignant cells with resulting shrinkage and softening of the tumor. In some cases the gland may return to its normal size and consistency, and when no evidence of metastases is found, radical surgery may be undertaken. There are insufficient statistics of the results of this operation on hormone treated glands to determine its value. Estrogenic therapy as well as orchiectomy may lead to regression of the metastases and obstructive symptoms may improve. Patients entering this hospital with acute symptoms of urinary obstruction due to the enlarged malignant gland have shown marked symptomatic improvement after hormone therapy, deferring the need for transurethral surgery. Hydronephrosis has subsided and roentgen evidence of return of urinary function to a non-functioning kidney has been observed.

Nesbit and Baum [6] reported the 5-year survival in a series of 588 cases. In the absence of metastases, they achieved best results (46 per cent, 5-year survival) by a combination of estrogens and castration. These statistics should be compared to the survival rates of radical surgery. Jewett [3] reported a 50 per cent 5-year survival, while Kimbrough [4] claimed a 64 per cent, 5-year survival. However, most of radically treated patients are alive without cancer as compared to the others alive with cancer.

At this hospital castration and orchiectomy are advocated in all cases of inoperable prostate neoplasms, whether or not metastases are present. After castration, extragonadal androgen production by the adrenals may be increased. Therefore, when symptoms and diagnostic follow-up studies reveal that the neoplasm has become refractory to hormone therapy, adrenalectomy may be advised. Adrenalectomy produces relief of pain in 70 per cent of the cases and induces a sense of well being. It does not cause a regression of the tumor nor

3. Jewett, H. J.: Journal of the American Medical Association, 156:1039 (August 1954)

4. Kimbrough, J. C.: Journal of Urology, 76:297 (February 1956)

5. Huggins, C.: Canadian Medical Association Journal, 50:301 (April 1944)

6. Nesbit, R. M. and Baum, W. C.: Journal of the American Medical Association, 143:1317 (March 1950)

does it prolong life. Cortisone causes atrophy of the adrenal gland and decreased androgen production. This drug is gradually replacing the surgical adrenalectomy, and the resulting atrophy of the adrenal is called 'medical adrenalectomy'. Precautions must be observed with prolonged use of cortisone. A low salt diet and potassium replacement are necessary. Reactivation of pulmonary tuberculosis and peptic ulcers may occur. If any surgery is required the patient should be observed very carefully since they are unable to tolerate operative stress.

During the past few years, radioisotopes have been injected locally in the treatment of prostatic cancer. Chromic phosphate p^{32} and radioactive gold, Au^{198} have been used. No cures have been obtained. Decrease in size of the tumor with clinical improvement has been noted. The radioactive isotopes have been unable to reach the metastases by lymphatic or hematogenous routes, and their action has been limited to the injected areas.

Excision of the pituitary gland to further decrease androgen production by the adrenal gland has been carried out, but the results to-date have not been satisfactory.

Alleviation of back pain due to spine metastases may be obtained by roentgen therapy to the involved vertebrae. This has given excellent temporary relief, although there is no apparent change in the appearance of the metastatic lesions.

SUMMARY

CANCER of the prostate is a slow, progressive, asymptomatic malignancy. When clinical symptoms appear, growth of the tumor has extended beyond the operative stage. Early diagnosis is essential for curative surgery. This is possible only by rectal examinations on all male patients over the age of 50 years. The male patient is not as cancer-conscious as the female and only 20 per cent of all patients examined at cancer detection clinics are male. The study of the aged by the medical profession should emphasize the need for rectal examinations as part of the physical examination and the high incidence of prostatic cancer of that age group should be publicized. The digital-rectal examination is diagnostic in 80 to 85 per cent of the cases and this simple method of diagnosis should be made a routine procedure by every physician.

Veterans Administration Hospital

Duodenal Malignancies*

Primary malignant neoplasms of the duodenum (excluding the papilla of Vater) are rare. Thirty-one cases were found at necropsy at the Mayo Clinic from 1910 through 1953, an incidence of 0.12 per cent. Twenty-seven were adenocarcinomas; the remaining four were sarcomas. There was no evidence that a benign ulcer had undergone neoplastic change. The commonest sites of metastasis were the regional lymph nodes and the liver.

The commonest features in this series were pain, loss of weight, vomiting, and anemia. Melena, jaundice, and an abdominal mass were prominent findings. A lesion was found by roentgenologic examination in 15 of 22 cases. In no case was a correct diagnosis made without positive roentgenologic evidence of the lesion.

*Burgerman, A., Baggenstoss, A. H., and Cain, J. C.: *Gastroenterology*, 30:421 (March, 1956)

Sanfurd G. Bluestein, M.D.

Paterson

Cobalt Radiotherapy: Two Years' Experience in a Private Office

Cobalt radiotherapy offers a new and valuable vehicle for the palliation and, perhaps, for the cure of many types of carcinoma.

Two years of treating cancer although not adequate to evaluate cure rates, is more than sufficient to recognize the advantages of a mode of therapy. Two years of treating patients with cobalt radiotherapy have convinced me that it is far superior to conventional deep x-ray therapy. The cure rate of most types of cancer by any means, including surgery, is surprisingly low. About 75 per cent of cancers are actually treated palliatively and with little prospect of cure.[1]

Radiotherapy is the most useful mode of palliation. Palliation is well worthwhile in a large proportion of incurable cases. Palliation is evaluated in two ways: (1) prolongation of life, and (2) alleviation of symptoms. Both are important accomplishments, and may be achieved singly or together.

If the goal is cure, as in carcinoma of the larynx, cervix, mouth, pharynx, and (sometimes) breast or esophagus, treatment is better accomplished by cobalt than conventional therapy. Some cancero-cidal doses which cannot be achieved by conventional therapy can be achieved by cobalt. In all cases, a higher dose can be administered with less systemic reaction, less damage to surrounding tissues, and less discomfort to the patient.

When alleviation of symptoms is the goal, radiation sickness is an undesirable side effect. The incidence of radiation sickness is greatly diminished in cobalt radiotherapy, because the integral dose is less than from conventional deep x-ray therapy. This is important to the seriously ill patient. To accomplish the goals of radiotherapy, adequate dosage must be achieved. If the patient is made too sick by the treatment, its value is vitiated. Often it is necessary to minimize radiation sickness lest the patient refuse to continue treatment. Also, if we cannot anticipate prolongation of life, so that simply alleviation of symptoms is the goal, making a sick patient sicker is defeating our purpose.

The difference in skin reaction is also important. Most patients, despite intensive therapy to doses double that causing moist desquamating reactions with conventional therapy, do not go beyond a brownish discoloration with dry scaling of the skin. Anyone who has used conventional therapy extensively knows the unhappiness produced by the usual wet skin reaction of conventional or grid therapy. He can then understand the pleasure of the therapist who is using cobalt. To be able to tell a patient that there will be no real burn from the therapy (contrary to what many patients expect) helps to win the patient's con-

1. Harris, William. Radiology 17:58 (March 1592)

fidence, and makes the therapy easier. I have seen occasional third degree burns from cobalt, but this rare effect is, I think, due to faulty technic.

Suppose the goal is to stop the cough and hemoptysis of a patient with inoperable carcinoma of the lung, but in doing so, you make him "sick to his stomach," so that he loses weight from inability to eat. Perhaps he gets a skin burn which becomes infected or requires antibiotics and local treatment, and which makes the patient generally uncomfortable. If all this happens, the purpose of the treatment is defeated by substituting one disease complex for another.

Lymphomas are a fertile field for radiotherapy. Everything that has been said relative to cancer can also be said here. If patients require therapy to different areas at intervals which sometimes may be short, the therapy which causes less side effects is definitely better. Nothing here that can be done with conventional x-ray cannot be done more easily and more comfortably for the patient with cobalt. In the occasional instances where additional treatment of a previously treated area becomes necessary and skin would become a limiting factor with conventional therapy, the advantages of cobalt are obvious.

Effective palliation is more readily accomplished with cobalt than conventional x-ray therapy, and without the unhappy side effects caused by conventional x-ray therapy.

Improvement in cure rate has not been adequately determined in the short period of time cobalt has been available. It is my impression that in certain types of cancer, cure rates will be enhanced.

Illustrative examples of cure and palliation are presented below. In all instances of palliation here cited, there was both prolongation of life and alleviation of symptoms.

CASE ONE

A 47-year old man was referred in August 1955 following surgery, because of an inoperable carcinoma of the right upper lobe. He was treated with anterior and posterior opposing 10 by 14 centimeter fields and received 8300 roentgens to one field, and 5200 to the other—until the tumor showed regression by x-ray. Following cobalt therapy the patient remained well, and although asymptomatic, developed the x-ray appearance of radiation pneumonia, without clinical manifestation. This has healed, and the patient remains well and at full work.

CASE TWO

An edentulous, 82-year old woman was referred in June 1955 with a carcinoma involving the right gingivo-buccal groove, gingiva and medial aspect of the cheek. The lesion measured 6 centimeters and could be covered by an intra-oral cone. The patient was a bad cardiac. Anesthesia and surgery were contra-indicated. She received 4100 roentgens through a 6 by 8 centimeter lateral field with cobalt, and 4000 roentgens through a 6 centimeter intra-oral cone with 140 kilovolt therapy. The patient made an uneventful recovery and remains well at present. There was no skin reaction and no residual effects on the cheek exteriorly.

CASE THREE

A 72-year old man came here in March 1955 with marked respiratory embarrassment due to chronic bronchitis and emphysema. He developed a lesion in the left upper lobe which was observed over a six month period, during which it grew rapidly. Nothing was done because it was felt that surgery was contra-indicated. This is one of two patients in our entire series treated without microscopic confirmation. The lesion was directly under the chest wall and was treated by a single 7 by 10 centimeter field. He received 6100 roentgens in 30 days and the lesion disappeared. There was no radiation sickness during therapy, and the skin showed merely a brown scaling. The patient died a cardiac death a year later without evidence of recurrence of his lesion.

CASE FOUR

A 43-year old man had an anaplastic carcinoma of the nasopharynx, extending from the level of the palate up to the base of the sphenoid. It went beyond the midline over to the right side and extended behind the cushion of the left eustachian tube. Thus, the entire left nasopharynx and a portion of the right was involved. Eight cervical nodes were microscopically positive. A left radical neck dissection was done and then the patient received cobalt therapy. In 35 days he received 4500 roentgens to 6 by 12 contralateral fields, and 2500 roentgens to one straight and one angled antral field. He tolerated therapy without any difficulties and aside from loss of taste had no complaints. At the time of the last followup in December 1956 the patient was well.

CASE FIVE

A 78-year old woman had an extensive 7 centimeter epidermoid carcinoma, involving the left gingivo-buccal groove and extending into the base of the tonsillar fossa. In September 1955, she refused surgery. She said that she would not come for more than three weeks of treatment. Because it was felt that only palliation could be achieved, she received 6000 roentgens in air in 23 days, through a single lateral field. The lesion healed completely, leaving no discernible evidence of the disease or the therapy. To date the patient remains well.

CASE SIX

In August 1955, I saw a 56-year old man with a bronchoscopic (microscopic) diagnosis of carcinoma of the left lower lobe, and positive cells from a left pleural effusion. In 34 days he received 5500 roentgens to an anterior and posterior 10 by 14 field and 2000 to a lateral field. The effusion then cleared and the patient returned to work. He was lost to followup until September 1956 when he returned with massive lymph node involvement in the left supraclavicular region. He was treated with cobalt to the supraclavicular region, and received 6700 roentgens in 22 days. The nodes disappeared and the patient returned to work and is well to date.

CASE SEVEN

An 80-year old man was first seen in August 1955. Five months previously he had had a squamous cell carcinoma of the right vocal cord extending to the epiglottis. It had been inadequately treated with deep x-ray therapy and had recurred in both locations—or had never completely disappeared. At the first visit to my office, there was a palpable node in the right side of the neck which was never biopsied. It had appeared following the previous therapy and was assumed to be metastatic. The patient received 6925 roentgens to the side containing the node and 3900 to the opposite through 6 by 9 fields with cobalt in 46 days. All lesions disappeared and the patient remains well.

CASE EIGHT

An 82-year old man had been treated for papillomatosis and papillary carcinoma of the bladder over the course of several years by timely fulguration. In August 1955, he came for cobalt therapy because of diffuse carcinomatosis of the bladder mucosa. He was extremely heavy and rather difficult to manage. It was felt that only palliation could be achieved. Because of this, he was treated with a single anterior field, 6 by 9 centimeters and received 5800 roentgens in 26 days. Six months after the completion of therapy the bladder was clear at cystoscopy and by biopsy and the patient has remained well to the present time.

CASE NINE

A 53-year old woman was referred in March 1955 because of carcinoma of the ovary with involvement of the peritoneum of the pelvic region, after a total hysterectomy and bilateral oophorectomy. She was a huge woman. Deep x-ray would have been useless because of skin limitations. She received 3500 roentgens to the entire pelvis through anterior and posterior 10 by 14 fields in 36 days. She is well at the present time and has returned to full activity.

CASE TEN

A 67-year old woman was treated in January 1955 for a large infected baso-squamous carcinoma of the skin at the outer canthus of the right eye. Superficial x-ray therapy was given with good response. In April 1955 she developed a pre-auricular node which showed squamous cell carcinoma by biopsy. This was treated by cobalt through a 4 centimeter circular field and received 5900 roentgens in 34 days. She has remained well since that time.

These cases are selected examples of interesting therapeutic results. Some represent excellent palliation and some are probably cures, although it is too early to be sure about this.

They demonstrate the large doses which may be administered by cobalt, without immediate untoward effects or discomfort to the patient. Rarely has a patient been unable to complete his course of therapy. All things being equal, any patient who has a carcinoma (other than a carcinoma of the skin) is better treated with cobalt than conventional deep x-ray therapy.

SUMMARY

COBALT radiotherapy is superior to conventional x-ray therapy in treatment of cancer because (1) higher doses can be achieved, (2) radiation sickness is less, (3) skin reactions are diminished, (4) palliation is enhanced and (5) cure rates may be increased.

591 E. 27 Street

Historical Article • • •

Jacob Bleiberg, M.D.

Newark

Witchcraft, Warts and Wisdom

Of all branches of cutaneous medicine, warts have been the most subject to folklore. In this graceful vignette, Dr. Bleiberg discusses some sidelights to the folklore of the subject, and presents a possible mechanism which can embrace both the emotional and the virologic aspects of warts.

Medicine is an art rather than a science because humans and their diseases behave whimsically and capriciously. One might say that this is all very well in emotional illnesses, but in a nice scientific infection, there are definite measurable factors. Given a certain number of germs of a determined virulence, and a host with a specific degree of immunity, or sensitivity, and one is led to expect, that with the application of indicated treatment (antibiotic, surgical, or immunity-producing) the germs must be routed forthwith, and the patient restored to health. But, accustomed as we are to victory over infectious disease, the common wart still frustrates us. Little doubt remains that it is infectious and contagious. The filterable virus that causes it has been successfully cultured on chick chorio-allantoic membranes. Auto-inoculability and human-to-human transfer have been observed many times. At least twice, human to animal transfer has been accomplished.

Common warts, as well as digitate, juvenile, filiform, genital and plantar warts, and even laryngeal papillomata, are all probably caused by the same virus. Traumatized areas are usually invaded, as well as areas of friction and pressure. Thus in nail-biters and cuticle-chewers, as well as in the fastidiously manicured, the tissues around and under the nails are often involved. A nineteenth century textbook describes a case in which warts infiltrated a freshly acquired tattoo on the arm of a sailor. In children the growths are frequently spread from the hands to the lips and nostrils, where they are highly resistant to therapy. In the bearded region warts are seeded into each razor nick, and several hundred lesions have been removed from the face of one individual. In the anogenital area growth is luxuriant, especially in pregnant women. The plantar area is often involved, producing disability. Here the warts may spread in the planes of the epidermis, involving the entire sole and/or heel with a mosaic pattern.

Epidemics are reported in recent American and British medical journals. The editor of the *Lancet* laments, " . . . much of our knowledge of the epidermiology (*sic!*) of warts is based on clinical impressions. The control of this disease is a dismaying task, since few reliable wart charmers have been recruited into the National Health Service."[1]

Here, then, is a paradox. A common, distressing disease, known to be infectious and contagious, with the causative virus identified, demands wart charmers for its treatment! This

1. Editorial in the August 6, 1955 issue of *Lancet* (London, England).

most inconsistent of all diseases behaves most capriciously in the sphere of therapy. After vainly trying a variety of medically accepted treatments, the therapist is amazed to see the lesions 'spontaneously' disappear some time later. He then decides to try expectant treatment and a placebo on his next patient. Now, in dismay, he sees new lesions sprouting almost daily, and spreading to others in the patient's family. The next patient is subjected to careful fulguration and curettement of each wart. Three months later he returns, usually with a large chip on his shoulder, and twice as many warts. Now the therapist is ready to try wart charming. If he knows how, his efforts are likely to succeed in from 50 to 85 per cent of cases, according to many authors. Skeptics scoff, and attribute all cures to the baffling tendency of warts to disappear 'spontaneously.' However, the fact remains that warts do vanish more often after properly applied suggestion, than can be explained by so-called spontaneous remission.

WHEN suggestion, or witchcraft if you will, is employed, as in all therapy, perfect rapport with the patient is essential. The therapist must have faith in his method, and he must be able to inspire faith and hope in his patient. Dr. Harold G. Wolff, of Cornell University, illustrates this with an observation of the Hopi Indians. They believe that anyone who treads on the track of a snake gets sore ankles. The older Indians, who have complete faith in the medicine man, prevent the pain by invoking the spells and incantations of the shaman. In contrast, the young American-schooled Indian, who considers the medicine man a faker, gets sore ankles when he steps on a snake track.

Methods of wart witchcraft may be divided into (1) those employing trauma, and (2) the non-traumatic. A grade school teacher in Newark some thirty-five years ago, cured the warts of her pupils by advising the application of their own saliva, in the morning before brushing the teeth. Toothpaste, she explained, killed the wart-destroying factor. One doctor gets a high incidence of cures in warts of the extremities, by tracing the outline of the involved limb on paper, pencilling in the warts with a great show of accuracy, and ceremoniously burning the paper. The classical dialogue of Tom Sawyer and Huck Finn on wart therapy needs no repetition here. All dermatologists have had success with the use of placebo x-ray, that is switching on the rectifier, but not the x-ray tube. This is especially effective if the rectifier is a noisy mechanical giant, with flashing lights.

An oncologist testifying before the New Jersey compensation bureau, in the course of cross-examination, qualified himself as a full-fledged witch doctor of the Quichi tribe.

IN NORTH AFRICA warts are cured by having the patient look at lightning, while invoking Sisi Bbwarak, a local saint. In many parts of the world, the application of human and animal secretions and excretions are still in vogue as wart cures. Some of the methods utilizing trauma are of interest. Cut crisscross into a Borsdorfer apple, and press the wart so forcefully with the cut surface as to cause pain. Then bury the apple in the ground. The wart will disappear as soon as the apple rots, if this has been done as the moon wanes. You may alternately use a piece of green, unsalted pork, rubbing the wart until the entire area turns red. Here too, however, the waning moon is required. A similar method must be carried out 'in the first glow of the new moon.' In rural Germany, a very valuable insect takes care of the wart problem. He is known as the longhorned grasshopper (*Dectitus verrucivoris*), colloquially 'der Warzenbeisser.' In any language, he bites off warts. The British Museum of Natural History has memorialized him with a good-sized model.

The *Encyclopaedia Britannica* states that the word "witch" is allied to the word "wit," meaning wisdom. The practice of witchcraft is as old as mankind, and with the establishment of a new religion, the gods of the old religion became the devils of the new. Devil, says *The Britannica*, is a diminutive of the root word "div," from which comes the adjective "divine." The practice of witchcraft flourished during the dark ages in Europe,

when learning retreated into monasteries, and feudalism ground the common people into the dust. Witchcraft for the serf and his family, became a way of life, a communal activity, carried out stealthily at night, to evade the cruelty of the lord of the manor and his henchmen. By "supernatural" means, the witch was trying to master the forces which made life unbearable. Actually, such efforts occasionally resulted in the mastery of some important natural laws. We learned the use of digitalis, for example, from a "wise woman" of Shropshire. Certainly part of our knowledge of the value of suggestion has come to us from witchcraft. In the eighteenth century, after twelve hundred years of Christianity, witchcraft all but disappeared from England. In France it is still practiced. In Italy, *la vecchia religione* has its adherents to this day. One is struck by the similarities in the witchcrafts of cultures, which could not possibly have been in contact with each other. The universality of the belief in the powers of the moon is a case in point. It is as if in response to a racial memory, harking back to a stage of evolution when the moon, and the tides it controls, determined the very life of the primitive organism.

WHY do some of these methods of wart charming work? Adherents of the "trauma" school insist that the tissue fluids of the cutis have an anti-viral effect. They bolster this with the statement that attempts to inoculate warts into the cutis are never successful, whereas, if the inoculum is carefully injected into the epidermis, successful "takes" are not uncommon. The anti-trauma believers say that the only effect of the injury is to spread the virus in the damaged areas. Here is another example of the strange dichotomy in most aspects of our knowledge of warts. Bonjour[2] said he cured warts by suggestion as early as 1888. He attributed his cures to a lowering of blood pressure by way of the autonomic nervous system. This, he argued, reduced the blood supply to the wart.

Wart charming can take many different forms, but the variety and bizarreness of its methods are surpassed by the soberly recommended orthodox treatments. High doses of x-ray have been suggested. Arsenic, orally, intravenously, intramuscularly and locally injected has been used. These are sledge hammers used to kill flies. Freezing with solid carbon dioxide or liquid nitrogen, applying alcohol jelly and igniting it, and even the homely soldering iron are still in use. Injection of distilled water intramuscularly proved equally efficacious with the still popular bismuth injections, in a controlled experiment. Recently, synthetic antimalarials, local injections of concentrated vitamin A, and application of a paste containing a vitamin B constituent, are undergoing investigation. Excision followed by skin grafting has been tried, especially when the wart is complicated by radiation burns, so that one sees hairy areas on the sole of the foot, with new warts at the edges of the grafts. Within recent years, warts lying over the heads of metatarsals have been treated by removing the section of bone beneath the wart. After the patient is ambulatory, the wart sometimes disappears. Suspensions of podophyllin are applied to genital warts with a high recovery rate, but reactions may be violent. Salicylic acid in ointments or plasters is of real value, but may require weeks of treatment. Heterohomohemotherapy has had its vogue, as have autohemotherapy, autogenous and stock vaccines of killed virus. Here, then, is a very small proportion of the innumerable methods used in wart treatment. These too may be classified into traumatic and atraumatic groups, just as were the "charms." All of them work when applied by adept practitioners who inspire hope and confidence. Recurrences seem commoner after treatments involving deep, painful trauma.

Why do such varied modes of treatment work? How can all the inconsistencies be explained? Leaving out all the methods involving actual destruction of the wart by freezing, sizzling, electrocution and charring, what is the factor which makes warts disappear either as the result of "wart charming" or orthodox therapy?

2. Bonjour, Etienne: British Journal of Dermatology, 41:324 (August 1929).

Viruses enter a cell and can alter the chemistry of that cell according to their needs. This alteration in chemistry may take place immediately after the penetration of the cell; or the host cell may go on functioning normally, undergoing numerous normal mitoses, until a trigger mechanism activates the dormant virus, causing it to multiply at the expense of the host cell. The first premise, then, is that *the wart virus is present in the epidermal cells of many individuals, as a dormant parasite.* It must then be postulated that the trigger is a chemical molecule. Such molecules could be elaborated as a result of emotional stress, with or without local injury, causing the warts to appear. If therapy is properly applied, be it salicylic acid plaster or a grasshopper bite, so as to inspire hope and confidence, the causative emotional tension is neutralized. The favorable climate for the virus' growth is eliminated. The warts disappear. It is not impossible that some substances may locally diminish the ability of the virus to grow. Certainly, podophyllin may function that way, at least in the non-cornified genital warts. The virus then may be destroyed, or it may return to a dormant state within the cell, lurking there, ready for re-activation with the proper stimulus. Only by assuming that the chemical effects of emotional stress play a part in the etiology of warts, is it reasonable to explain the effectiveness of suggestion in their treatment. Linus Pauling has pointed out that we are on the threshold of molecular medicine. We must begin to think in terms of the chemistry of suggestion.

The author acknowledges with gratitude, the assistance of Dr. William B. Ignatoff in the preparation of this paper. His interesting and informative lecture on warts was most helpful.

31 Lincoln Park

Hazards of Hair Bleaching

In becoming a blonde, the peroxide way, a woman stands the risk of losing many of the most prized properties of her hair, the secretary of the American Medical Association's committee on cosmetics warns.

Mrs. Veronica Conley said in *Today's Health,* that a woman must answer three questions before bleaching her hair. They are: Will her skin blend well with blonde hair? Can she afford the added professional care? Is her hair sufficiently healthy and sturdy to stand the assault of a bleaching agent without disastrous damage?

Mrs. Conley pointed out that no matter how pretty a shade of blonde is on one person, it may not be on another. Complexion and hair must complement one another. Treating the hair with peroxide most often produces a harsh yellow shade, particularly unflattering to all but the very young. Adding a hair dye of suitable shade in the blonde range softens and refines the harshness of peroxide, but the strain on the hair is considerably increased when it is subjected to two hair-coloring processes, she said.

Bleached hair looks dry and is brittle and curl-resistant. Under a microscope changes in the hair are apparent. There is little doubt that bleaching weakens the hair, she said, because the bleach must penetrate through the major part of the hair to the pigment in the center of the shaft.

Hair bleaching requires skill and should be entrusted to no one but a professional beauty operator with much skill, Mrs. Conley said. This constitutes not only an initial but a continual drain on the budget. Hair grows about one-half inch a month, so that newly grown hairs must be bleached at least this frequently.

Added to this is the problem of grooming bleached hair. It is curl-resistant and permanent waving and routine setting after shampoos produce inferior results.

Mrs. Conley concluded that a woman in thinking about hair bleaching must remember that her hair's sheen, its ability to take and hold a curl, and its general healthy look are often sacrificed. In addition, it takes time and money to keep bleached hair looking its best.

Trustees' Meeting: January 13

At its meeting on January 13, 1957, the Board of Trustees:

—Welcomed to New Jersey, the newly appointed A.M.A. Field Secretary, Mr. Thomas A. Hendricks.

—Adopted a resolution endorsing the Community Homemaker Service in the interest of easing the care of homebound chronically ill.

—Agreed, in principle, with the desirability of establishing a cardiopulmonary function laboratory in New Brunswick.

—Authorized the President to convene a constitutional convention for reviewing proposed revisions to the Constitution and By-laws of our society.

—Approved use of some of the moneys in our Permanent Capital Fund for the Medical Student Loan Fund.

—Created a committee on Medicare Disputed Bills.

—Made $5000 available to Medical Service Administration for 1957 operating expenses in accordance with our budgetary allotment for this purpose.

—Named Dr. Vincent P. Butler and Dr. Carl N. Ware as our representatives to the Chicago Poliomyelitis Conference, sponsored by the American Medical Association.

—Approved the establishment of a joint conference committee with representatives from the Nurses' Association and the Hospital Association.

—Created the post of Historian-Archivist for The Medical Society of New Jersey, with a view towards developing a sound historical resume for our bicentennial 1966.

—Approved modifications in our pension plan necessary to make it acceptable to the Internal Revenue Service.

—Appointed Dr. Henry A. Davidson as this Society's representative to the State Commission on Mental Health.

—Heard a discussion as to whether it would be proper for a member of our Society to accept affiliation with an essentially osteopathic hospital, and in this respect accepted the following opinion of our Judicial Council:

> The Judicial Council unanimously agreed that the answer to these questions can be found in Chapter II, Section 1 of the Principles of Medical Ethics of the American Medical Association which states: ". . . All voluntarily associated activities with cultists are unethical . . ." The Judicial Council unanimously reaffirmed its opinion that association with osteopathic physicians as professional co-equals, in or out of hospitals, contravenes the Principles of Medical Ethics of the American Medical Association and is therefore unethical. In consequence, *under no circumstances* can it be condoned.

—Was advised that a hundred or more physicians in this state had signed a petition urging the legalization of euthanasia. Approved the following statement of our position in this regard:

> The attention of the Board of Trustees of The Medical Society of New Jersey has been called to a recent news item which reported that 166 New Jersey physicians had signed a petition calling on the Legislature to legalize euthanasia. The Board of Trustees wishes to point out that as private citizens those physicians have the right to their own opinions and actions, but those opinions are not to be construed as reflecting the official and accepted position of organized medicine regarding euthanasia. The practice of euthanasia has been and continues to be in conflict with accepted principles of morality and sound medical practice.

—Approved, as below indicated, the following recommendations of the Welfare Committee:

1. To promote infant welfare, it is officially recommended to the hospitals of New Jersey, that statistical reports be compiled of the perinatal mortality rates in each hospital; and that joint meetings be held between the staffs of the obstetrical and pediatric departments at stated intervals for discussion of these reports.

2. That the official position of The Medical Society of New Jersey be that no reference to physicians should appear in legislation affecting optometry other than such reference as occurs in specific exclusions of the applicability of such laws to physicians.

3. That the program of psychiatric services in general hospitals be referred to the Medical-Hospital Liaison Committee.

4. That the education of physicians in the field of rehabilitation be promoted by such means as:

   (a) Establishment of a Committee on Rehabilitation in each county medical society.

   (b) The designation of one meeting on rehabilitation by each county medical society.

(c) The investigation and surveying of facilities available in all communities — as to source of patients and treatment facilities.
(d) A mid-year meeting of the committee with county chairmen to discuss county problems in the field of rehabilitation.

5. That The Medical Society of New Jersey request the cooperation of the Woman's Auxiliary to The Medical Society of New Jersey in conducting a series of contests at county level, the winners of which would compete for awards at state level, which awards would be presented in the course of the annual meeting of The Medical Society of New Jersey each year.

6. That The Medical Society of New Jersey consider the desirability of establishing an award to be made annually at the annual meeting, preferably at the banquet, to those members who in the current year completed, or have completed, fifty years of medical practice.

Disclosure of Medical Information

ROBERT M. BACKES, Counsel, The Medical Society of New Jersey

A question has been raised concerning the disclosure of confidential medical information to non-medical personnel. The basis for the question is the increasing tendency of people in industry and other groups to ask for the diagnosis of illness of absentee personnel and to receive and process such information through office personnel with the possible result of embarrassment or harm to the patient through that or further dissemination of such information.

The solution to the problem is not an easy one. It cannot properly be resolved, in view of the interpretation of our laws, by a blanket agreement or directive not to reveal patient information to any other than medical personnel. Nor is it fair to impose upon the inquirer in every case the burden of obtaining written permission of the patient as a prerequisite to disclosure.

Although at common law communications between physician and patient were not privileged, a majority of our states (30 plus District of Columbia) have passed statutes of one kind or another granting such a privilege. New Jersey is not one of those states. It adheres to the more progressive, even though minority, view that the *public welfare outweighs the right of the individual patient to have his communications to physicians free from disclosure.*

There does exist in New Jersey, however, a right of privacy. This is the right of an individual to be free from unwarranted publicity; to be let alone; to be protected from any wrongful intrusion into his private life, which would outrage or cause mental suffering, shame, or humiliation to a person of ordinary sensibilities. This right of privacy is limited, and is not always superior to the right of the public, but must be construed in the light of the individual's relation to the community of which he is a member. For example, the duty of witnesses to give testimony in matters vital to public interest is paramount to any personal right of privacy. And in balancing the private interest with the public interest, the weight favors the public, provided there is no abuse of power.

In New Jersey there is almost no law pertaining to the question of how far a physician may go in disclosing to third persons details concerning his patient without invading the individual's right of privacy. However, some basis for interpretation is gained by the decisions of our sister states which have statutes making the physician-patient relationship a confidential one. Even in those states a physician may be justified in disclosing medical details where it is necessary to prevent the spread of contagious disease; where it is necessary for the protection of one who it is reasonable to suppose might otherwise be exposed, and, where in each of the above cases it is done in good faith, without malice, and the grounds for the diagnosis are reasonable. It would appear to follow logically that our right, as well as our obligation to disclose, is at least as great as those states regulated by specific privilege statutes.

The disclosure of information to non-medical personnel therefore requires an examination of the facts in each case on their individual merits based upon the considerations herein set out.

Offices To Be Filled By Election

1957 Annual Meeting

Office	*Term*	*From*		*To*		*Incumbent*
President-Elect	1 year	May	1957	May	1958	Albert B. Kump, Bridgeton
First Vice-President	1 year	May	1957	May	1958	Kenneth E. Gardner, Bloomfield
Second Vice-President	1 year	May	1957	May	1958	F. Clyde Bowers, Mendham
Secretary	1 year	May	1957	May	1958	Marcus H. Greifinger, Newark
Treasurer	1 year	May	1957	May	1958	Jesse McCall, Newton
Trustees:						
2nd District	3 years	May	1957	May	1960	Joseph P. Donnelly, Jersey City
3rd District	3 years	May	1957	May	1960	L. Samuel Sica, Trenton
4th District	3 years	May	1957	May	1960	Reuben L. Sharp, Camden
11th Trustee	3 years	May	1957	May	1960	Harrold A. Murray, Newark
Councilors:						
1st District	3 years	May	1957	May	1960	Ralph M. L. Buchanan, Phillipsburg
4th District	3 years	May	1957	May	1960	Daniel F. Featherston, Asbury Park
A.M.A. Delegates:	2 years	January	1958	December	1959	William F. Costello, Dover
		January	1958	December	1959	Aldrich C. Crowe, Ocean City
A.M.A. Alternates:	2 years	January	1958	December	1959	Albert B. Kump, Bridgeton
		January	1958	December	1959	Elton W. Lance, Rahway
Delegates and Alternates to Other States:						
New York						
Delegate	1 year	1958 New York Convention				William F. Costello, Dover
Alternate	1 year	1958 New York Convention				Peter H. Marvel, Northfield
Connecticut:						
Delegate	1 year	1958 Connecticut Convention				Blackwell Sawyer, Toms River
Alternate	1 year	1958 Connecticut Convention				Baxter H. Timberlake, Atlantic City
Standing Committees:						
Publication	3 years	May	1957	May	1960	J. Lawrence Evans, Jr., Leonia

Your Responsibility in the Use of X-rays and Other Ionizing Radiation

Statement by the United Nations Scientific Committee on the Effects of Atomic Radiation

The United Nations General Assembly, aware of the problems in public health created by the development of atomic energy, established a Scientific Committee on the Effects of Atomic Radiation. One of its urgent tasks was to collect information on the amount of radiation to which man is exposed today, and on the effects of this radiation. Radiation due to diagnostic radiology and to radio-therapy constitutes a substantial proportion of the total radiation received by the human race.

Modern medicine has contributed to the control of many diseases and has substantially prolonged the span of human life. These results have depended in part on the use of radiation in the detection, diagnosis and treatment of disease. There are, however, few examples of scientific progress that are not attended by some disadvantages. Thus, irradiation of human beings, and particularly of their germinal tissues, has certain undesirable effects. While many of the somatic effects of radiation may be reversible, germinal irradiation normally has an irreversible and cumulative effect. Any irradiation of the germinal tissues involves genetic damage. For somatic effects there may, however, be thresholds for any irreversible effects, although if so these thresholds may well be low.

The information so far available indicates that the human race is subjected to natural radiation,[1] as well as to artificial radiation due

to its medical applications, to atomic industry and its effluents and to the radioactive fallout from nuclear explosions. The Committee is aware of the potential hazards that such radiation involves, and it is collecting and examining information on these subjects. The radiation received for medical purposes is now, in certain countries, the main source of artificial radiation and is about equal to that from all natural sources. Moreover, since it is given on medical advice, the medical profession exercises responsibility in its use.

The Committee appreciates fully the value of the correct medical use of radiation, in the diagnosis, in treatment, in the early mass detection and in the extension of medical knowledge. And it certainly acknowledges the tremendous contribution of the radiologic profession, through the International Commission on Radiologic Protection [2] in recommending maximum permissible levels of irradiation. With respect to those whose occupation exposes them to radiation, the establishment of these levels depends on the view that there are doses which (according to present knowledge) do not cause appreciable body injury in the irradiated individual; and also on the consideration that the number of people concerned is sufficiently small for the genetic repercussions upon the population as a whole to be slight. Whenever exposure of the whole population is involved, however, it is prudent to limit the dose of radiation received by germinal tissue from all artificial sources to an amount of the order of that received from the natural background radiation. The Committee believes that medical irradiations of any form should be restricted to those which are of value and importance, in investigation or in treatment, so that the irradiation of the population may be minimized without any impairment of the efficient medical use of radiation.

The Committee is anxious to receive information as to the methods and the extent by which such economy in the medical use of radiation can be achieved, both by avoiding examinations which are clearly indicated and by decreasing the exposure to radiation during examinations, particularly if the gonads, or the fetus lie in the direct beam of radiation. It seeks to obtain information as to the reduction in radiation of the population which might be achieved by improvements in instrument design by fuller training of personnel, by local shielding of the gonads, by choosing appropriately between radiography and fluoroscopy, and by better administrative arrangements to avoid any necessary repetition of identical examinations. The Committee earnestly seeks the cooperation of the medical profession to make possible an estimate of the total radiation received by the germinal tissue of the population before and during the child-bearing age. It is essential that standardized methods of measurement be widely used to obtain this information. It emphasizes the value of adequate records, maintained by those using radiation medically, by the dental profession, and by the responsible organizations in allowing such radiation exposure to be evaluated. Information of this type will make it possible to decrease the total medical irradiation of the population while preserving and increasing the value of the medical uses of radiation.

1. The radiation due to natural sources causes between 70 and 170 millirem of irradiation to the gonads *per annum* in certain countries in which it has been studied. Higher values are found locally in some areas. See the reports "The hazards to man of nuclear and allied radiations" by The United Kingdom Medical Research Council in June 1956, in which also the millirem is defined; and from information submitted to the Committee.

2. See the report of the International Commission on Radiologic Protection (published in the British Journal of Radiology, December 1954).

New Children's Unit at NJNPI

On February 27, the New Jersey Neuropsychiatric Institute dedicated a 100-patient children's unit, the Allen Building. Named in honor of Frederick H. Allen, M.D., the distinguished orthopsychiatrist, the building will be devoted to the study of emotional problems in children. Director of the unit will be Isobel P. Rigg, M.D. Physicians interested in information about admission of children to the Allen Building may obtain it by writing to Dr. Rigg at p. o. box 1000, Princeton, N. J.

Announcements • • •

You Too Can Be a Latter-Day Jenner

A new series of prizes for family physicians of any country has been announced in London by Benger Laboratories. The prizes total $1400 and will be known as the "Benger Prizes for Original Observations in General Practice." Entries will be judged by the British College of General Practitioners.

"The ideas or hunches which we are looking for may be concerned with the cause, diagnosis, treatment or prevention of any disease," explained the donor. "All usable entries will be published and the book will be available to physicians everywhere. We hope that the physicians' ideas will prove a stimulus to medical research workers everywhere, whether in hospitals, special institutions or pharmaceutical companies.

"I believe that among the obscure and unassuming family doctors of the world there may be another Jenner or another Lind. I believe it although the experts say there is no great untapped reservoir of talent. I prefer to the statistics of the expert my own hunch that there are many doctors only waiting for an opportunity to put their own ideas, born of experience, at the service of humanity."

Entries may be in any form and of any length. All family physicians, anywhere in the world, are eligible to participate. Manuscripts or correspondence should be addressed to Benger Laboratories, Ltd., Holmes Chapel, Cheshire, England.

Trenton Approved for 3-Year Residency

Announcement has been made that the State Hospital at Trenton has won full three-year approval for the training of residents in psychiatry. Only 31 of the country's 200 State Hospitals have such approval, and this is the first State Hospital in New Jersey to win it. The program includes affiliation with the Child Guidance Center in Trenton, with the Institute of the Pennsylvania Hospital in Philadelphia and with the State Hospital's own network of mental hygiene clinics.

Psychiatrists Needed

The Martland Medical Center in Newark offers unique opportunities for service, prestige, experience, professional contacts and participation in research and teaching. Any psychiatrist who is not donating services now should consider affiliating himself with this public hospital. Write to Dr. Morton Stern for details. The address is 24 Girard Place, Newark 8.

International Cancer Congress

The Seventh International Cancer Congress will be held in London, England, July 6 to 12, 1958.

There will be two basic sessions of the Congress: (a) experimental and (b) clinical. Included in the spotlight will be hormones and cancer, chemotherapy, carcinogenesis and cancer of the lung.

Would you like to submit a paper? Submit it with an accompanying abstract (not over 200 words) before October 1, 1957. Send it to the address below.

Registration fee is $30. Closing date for registration will be January 1, 1958.

Registration forms and a preliminary program will be sent to you on application to Seventh International Cancer Congress, 45 Lincoln's Inn Fields, London, W. C. 2, England.

Psychiatric Nursing Seminar

An all-day colloquium on psychiatric nursing is announced for Wednesday, April 17 at the Essex County Overbrook Hospital, Cedar Grove, New Jersey.

All physicians and nurses are welcome. There is no registration fee.

Dr. Morris Schwartz, the distinguished sociologist will give the keynote address at 10 a.m. He will talk on the "anthropology of the mental hospital ward."

Cancer Seminar on March 30

An all day Saturday seminar on cancer is scheduled for the Newark Presbyterian Hospital (27 South Ninth St.) March 30. The seminar opens at 9:30 a.m. with a talk by Dr. G. H. Twombly on cancer of the endometrium. The emotional implications of cancer will be discussed at 10:30 a.m. by Dr. Arthur Sutherland. At 11:30 Dr. John Daly will talk on carcinoma of larynx and pharynx.

After the luncheon adjournment, the seminar will resume at 2 p.m. with a talk on cobalt therapy by Dr. Gilbert Fletcher of Houston, Texas. At 3 p.m. Professor William Scott of Johns Hopkins will present a review of modern treatment of carcinoma of the prostate. The final paper of the day, at 4 p.m. will be by Dr. Milton Friedman, who will talk on irradiation of the esophageal cancer.

All physicians are invited. Further details may be obtained from the Medical Director Presbyterian Hospital, 27 South Ninth St. Newark 7, N. J.

Geriatric Symposium

On Wednesday afternoon March 13, there will be a symposium on problems of the aging. This will be held at the VA Hospital in East Orange starting at 2 p.m. Speakers will be Dr. Franz Kallman who will discuss genetic aspects of senile disorders and Dr. Nolan D. C. Lewis who will talk on maturity and mental hygiene.

Rehabilitation Meeting

A meeting of the Eastern Section of the Congress of Physical Medicine and Rehabilitation will be held on Saturday, April 27 at the Kessler Institute in West Orange. The scientific program runs from 10 a.m. to 5 p.m. and will be followed by cocktails and dinner at the Mayfair Farms, 481 Eagle Rock Avenue, West Orange. Dr. Henry H. Kessler will be the dinner speaker. You are invited. For further information and/or dinner reservations, write to Dr. Elmer J. Elias, 474 Greenwood Avenue, Trenton, N. J.

Courses in Hypoxia

Intensive courses in resuscitation are announced for New York on May 3 and 4 and again on June 7 and 8. These practical courses have proved of life saving value to many physicians. For more details write to Dr. Paluel J. Flagg, 2 East 63rd St., New York 21, N. Y.

A Chance to Go to Hawaii

More than 1,500 top medical minds from 20 countries will invade Hawaii this November. Surgeons from such diverse areas as Japan, Thailand, Indonesia, Alaska and Venezuela will discuss problems peculiar to their countries but of interest to New Jersey doctors. All subspecialties of surgery will be covered.

Scientific sessions will be limited mainly to the mornings and the central attraction will be a historical pageant telling the long story of a milennium of Pan-Pacific medicine and surgery.

Doctors from New Jersey are invited to attend the Congress, and assurance is given that Hawaiian hospitality will be lavished on both you and your families. Write to the Visiting Doctors' Bureau, 323 Geary St., Honolulu T. H., for details.

Course in Kidney Diseases

If you can devote two full days to it, you can take an intensive course in the management of renal disease in New York. The two days are June 24 and June 25 (Monday and Tuesday) and further details may be obtained from the Associate Dean, Postgraduate Medical School, 550 First Avenue, New York 16, N. Y. This course is directed by Dr. Lawrence G. Wesson. It will include the selection and interpretation of clinically available tests for the estimation of renal function. The advantages and disadvantages of each test will be considered.

Obituaries • • •

DR. FRANK G. CLARK

For more than half a century, Frank Garwood Clark administered to the medical needs of Hunterdon County. Only last year, the Hunterdon County Medical Society awarded him a unique gold key for 50 years of dedication to the people of the county. And on Christmas eve, 1956, the children of Whitehouse dedicated their program to him and gathered at his home to sing carols in his honor. On January 28, at the age of 79, Dr. Clark died.

He was born in Cumberland County, New Jersey, during the presidency of Rutherford B. Hayes. In 1906 he was graduated from the old "Medico-Chi" in Philadelphia and on Christmas eve that year, he opened his office in Whitehouse Station. His plan was to remain a short time and then move on to California. But he became enamored of Hunterdon County; and the people of that county became devoted to Frank Clark.

DR. NATHANIEL L. GREENFIELD

On January 11, 1957, Dr. Nathaniel L. Greenfield died of a coronary attack at the untimely age of 50. Born in New York City, Dr. Greenfield won his M.D. degree at the University of Vienna in 1938. Dr. Greenfield became pediatrician at the Princeton Medical Group and retained staff affiliations at the Roosevelt Hospital in New York City and at the Princeton Hospital. He was active in committee work with the Mercer County Medical Society and also served the National Foundation for Infantile Paralysis.

Dr. Greenfield lived in Cranbury, New Jersey.

DR. PAUL M. MECRAY

Dr. Paul M. Mecray, emeritus chief of staff at Cooper Hospital died on February 14, 1957, at the age of 85. A native of Cape May, he was graduated from the Medical School of the University of Pennsylvania in 1892 and returned to New Jersey to intern at the Cooper Hospital. He remained identified with that hospital for the rest of his professional life, becoming chief of staff there in 1924.

Dr. Mecray was a surgeon who was on the staff of several hospitals in Southern New Jersey. He was one of the founders of the American Board of Surgeons and held all the offices in the Camden County Medical Society. For two decades he was the secretary of that society. Dr. Mecray was surgeon to the New Jersey Society of Colonial Wars and in the Spanish-American War he was a colonel in the United States Army.

DR. MARCUS NEWCOMB

One of New Jersey Medicine's most effective and colorful careers came to a close on January 18, 1957 with the death on that day of Dr. Marcus Newcomb. In 1935 Dr. Newcomb was President of The Medical Society of New Jersey. He had been a member of the state legislature and was, for many years, superintendent of the Burlington County Hospital for Chest Diseases — an institution that was subsequently renamed, in his honor, the Newcomb Hospital. A New Jersey native, he received his M.D. degree in 1903 from the Jefferson Medical College. He practiced in Burlington County from 1904 to 1912 when he organized, at Browns Mills, a private sanatorium for diseases of the chest. This was the first private institution in history to win a charter from New Jersey's State Board of Health. In 1919, the freeholders of Burlington County invited him to head their tiny tuberculosis hospital in New Lisbon. Dr. Newcomb developed this from a 4-bed to the present 110-bed institution. Dr. Newcomb was Speaker of the New Jersey Assembly and also served as majority leader. He was also active in national association affairs and was 77 years old at the time of his death.

DR. JOSEPH R. WEINTROB

Suddenly on January 28, 1957, Dr. Joseph R. Weintrob died at his home in Margate. He was only 44 years old when he suffered a fatal heart attack. Born in Plainfield, Dr. Weintrob received his M.D. degree at the Jefferson Medical College in 1933. He interned in Atlantic City and for the next twenty years remained identified with that part of New Jersey. During the war he was a major in the medical corps. Dr. Weintrob did graduate work in ophthalmology at the Philadelphia General Hospital and at the University of Pennsylvania and in 1947 was certified as a diplomate in his specialty by the American Board of Examiners in Ophthalmology. Dr. Weintrob became chief of ophthalmic surgery at the Atlantic City Hospital.

County Society Reports • • •

Atlantic

The regular monthly meeting of the *Medical Society of Atlantic County* was held at the Children's Seashore House, December 14, 1956 at 9:00 p.m. The president, Dr. Baxter Timberlake, presided.

Speaker of the evening was Peter Randall, M.D., Associate in Surgery at the University of Pennsylvania. His subject was the treatment of burns.

Dr. Randall stated the incidence of burns has always been present, but if there is an atomic war it is estimated that 85 per cent of the casualties will be burns of varying degrees. In spite of the problems of burns through the years, the mortality rate has decreased only about 5 per cent in the last 100 years. This small decrease is probably due to modern methods of handling infection and shock.

The paper was discussed by Dr. Stamps and he voiced the appreciation of the Society for this excellent presentation.

The business meeting was opened by Dr. Timberlake with discussion of the treatment of dependents of service personnel. Doctors were advised to hold their bills until the fee schedule is available.

Dr. Green, substituting for Dr. Walter Stewart of the poliomyelitis committee, presented the problems of distribution of the Salk vaccine. He drafted a resolution which as amended, is as follows:

> Be It Resolved that the Salk vaccine be made available to all persons eligible for the vaccine for the purpose of immunization. The vaccine will be administered by the Board of Health of the local communities, under the direction of the public health officers of the separate communities, and their medical staffs, in conformity with the directions of the New Jersey State Department of Health.

There was considerable discussion, and Dr. Salasin brought out that he had dispensed at least ten thousand units. Thirty thousand units of Salk vaccine have been sold at local stores. Therefore, at least forty thousand units have been given in this area, and the community has done a fair job under the present system. He also stated that there was considerable force being applied to his department to organize a free clinic.

Dr. Dyer presented the situation in Ventnor. There was further discussion by Drs. Gleason and Marvel. Dr. Allman again gave his opinion and the opinion of The Medical Society of New Jersey and of the American Medical Association.

The resolution was committed to the poliomyelitis committee for further study.

The *Medical Society of Atlantic County* held its regular meeting at the Children's Seashore House on January 11. Dr. Baxter Timberlake called the meeting to order at 9 p.m. and introduced our guest speaker, Elmer L. Severinghaus, M.D., Vice-President for Clinical Research at the Hoffmann-LaRoche Company.

Dr. Severinghaus presented us with a very complete and interesting exposition on "Nutrition in Health and Disease." Dr. Donald Davidson discussed the presentation as did Drs. Kaman and Murray.

Mr. Kenneth Walton representing our local Chamber of Commerce and the Progress Council urged our Society to favor a Parking Authority to help solve Atlantic City's parking problem by setting up modern central city parking facilities with tax-free bonds.

Dr. Morton Leach announced that the local Muscular Dystrophy Association has funds available to supply crutches and chairs for any deserving patients.

The business meeting was adjourned and refreshments were served.

LEONARD B. ERBER, M.D.

Reporter

Camden

The regular monthly meeting of the *Camden County Medical Society* was held at the Cooper Hospital February 5, with Dr. George P. Meyer presiding.

Drs. Howard D. Easling, Vera D. Easling, Clarence L. Lehman, Thomas M. Madden, John A. Marchesani, Martin H. Weitberg and Edwin E. Ziegler were introduced to the Society after taking the membership oath and signing the register.

The scientific program was moderated by Dr. William T. Snagg. The following cases were presented: "Pulmonary Stenosis," presented by Dr. Jacob Drossner and discussed by Dr. E. N. Murray; "Surgical Treatment of Recurrent Carcinoma" presented by Dr. Paul Mecray, Jr.; "Ectopic Pregnancy" presented by Dr. John Franzoni by invitation and discussed by Dr. Hammell P. Shipps; and "Bronchiectasis" presented by Dr. James G. Dickensheets.

For the Executive Committee, Dr. Grimes advised the Society of the proposed amendment to the State Society's constitution providing for the enlarging of the Board of Trustees to 21 members plus officers. He recommended that our delegates be instructed to vote *against* the amendment at the annual meeting.

For the Nominating Committee, Dr. Halbeisen advised that we are now entitled to one more delegate and alternate at the spring convention, and that the death of the late Dr. Albert B. Davis,

created a vacancy in the alternates list. Dr. Edward G. Osborn was elected as delegate and Dr. Edgar T Gibson as alternate, term ending 1959, and Dr. Chauncey McGeorge as alternate, term expiring 1957.

The President requested that Dr. Halbeisen inform the Society which was the proper heart fund to support — the Camden County Heart Association or the Camden County Heart Aid. Dr. Halbeisen brought out that the Camden County Heart Association was a component member of the State and National Heart Association and was therefore the only one which should be supported by the physicians.

Dr. Edwin N. Murray read a memoir on the late Dr. I. Grafton Sieber.

EUGENE H. KAIN, M.D.

Reporter

Hudson

Under the chairmanship of Dr. John E. Annitto, *Hudson County Medical Society* met in regular session on January 8 at Murdoch Hall, Medical Center.

The Society voted that the sum of $600 be withdrawn from the general fund and forwarded to the American Medical Society of Vienna, for the relief of Hungarian physician-refugees in Austria.

Statements attributed to Dr. I. S. Ravdin, chairman of the Board of Regents of the American College of Surgeons, in the December issue of *Medical Economics*, were criticized from the floor. The item was headed, "Surgical Trainees Need More Ward Patients."

Dr. Henry Frenkiel of Hoboken and Dr. Martin H. Perle of West New York were elected to active membership.

Dr. Annitto announced that the New Jersey Consultation Service for Convulsive Disorders is arranging an extension clinic for Hudson County at St. Mary's Hospital, Hoboken, on March 11.

Guest speaker was Dr. Harold J. Jeghers, Professor of Medicine and Director of Department of Medicine at Seton Hall College of Medicine and Dentistry. Dr. Jeghers presented an illustrated discourse on "Oral Lesions Diagnostic of Systemic Disease."

HAROLD C. BENJAMIN, M.D.

Reporter

Mercer

The *Mercer County Medical Society* held its regular meeting on Wednesday, January 9 in the auditorium of the Trenton State Hospital. The members of the Society were the guests of Dr. Harold S. Magee, Superintendent, and his staff. Dr. Magee is a past president of the Mercer County Society. Dr. J. M. Schildkraut, President, presided and introduced Dr. Magee.

The program began with discussions by members of the hospital staff on the tranquilizing drugs. This was followed by individual case history presentation of three patients by the members of the staff. Following each discussion the patient was presented to the assembled group for evaluation of the efficacy of the drugs. At the conclusion of the program, a question and answer session was held and members of the society were privileged to direct questions to members of the hospital staff.

A social hour followed the regular meeting.

DAVID ECKSTEIN, M.D.

Reporter

Middlesex

The regular monthly meeting of the *Middlesex County Medical Society* was held at Roosevelt Hospital, Metuchen, on Wednesday, January 16. The meeting was called to order at 9:15 p.m., by the president, Dr. S. D. Becker. The Judicial Committee presented applications for membership from: Dr. Richard Kirchner for regular membership by transfer from the Philadelphia County Medical Society and, Dr. Mark H. Lund, for associate membership. Both were unanimously approved by the Society.

The meeting was then turned over to Mr. Ernest Abelson who delivered an interesting "Talk on Investments." The subject was pursued at length with questions afterwards.

The president announced that because we now had 268 active members in our Society, we are entitled to another delegate and alternate to the House of Delegates. Dr. Reuben Levinson was unanimously approved as delegate and Dr. Rudolph Matflerd as his alternate. Dr. Levinson thereupon resigned as alternate and was replaced by your reporter as alternate.

M. M. KLEIN, M.D.

Reporter

Morris

The *Morris County Medical Society* met for its regular January meeting at Spring Brook Country Club on Thursday evening, January 18. Members of the Morris County Bar Association were guests. A purely social meeting was a change from the usual procedure; no business was transacted, and no speeches were made. Professional entertainment and dinner highlighted the evening.

ALBERT ABRAHAM, M.D.

Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held on December 11, 1956 at the Medical Society Building. Dr. Abraham Shulman, the president, presided.

The following were elected to membership: Dr. John D. Brown of Pompton Plains; Dr. Frank Wadolkowski of Lyndhurst and Dr. James J. Whitford of Clifton. Dr. Sherwood Jacobson of Paterson was made a courtesy member.

Dr. Shulman suggested that the members purchase car emblems from the Society Office; also that they mail the return cards to the Office, indicating their willingness to enroll for Medical-Surgical coverage.

Dr. Earl Warren introduced Mr. Mac Ewan, Executive Vice-President of the Paterson Chamber of Commerce, who spoke of the many activities of the Chamber. He urged the physicians to become more actively interested in the affairs of the City by working along with the Paterson Chamber of Commerce.

Dr. Shulman introduced the guest speaker, Henry C. Falk, M.D., Director of Gynecology, Beth Israel Hospital, N. Y. Dr. Falk's subject was "Carcinoma of the Uterus—Diagnosis and Management."

At the close of the program, a collation was served at a table arranged attractively in keeping with the Holiday Season, by the Chairman of the Hospitality Committee of the Woman's Auxiliary.

The regular monthly meeting of the *Passaic County Medical Society*, in joint sponsorship with the Passaic County Heart Association, was held on Tuesday, January 15 at St. Joseph's Hospital in Paterson. This meeting was, in the main, a memorial lecture as a tribute to the late Dr. Meyer Notkin, a former member of both groups. The meeting was opened by Dr. Abraham Shulman, President of this Society.

Elected to active membership were Dr. Archie Handler of Passaic and Dr. Samuel M. Schlyen of Rutherford. Elected to Associate Membership was Dr. Irwin Lee Maskin of Fair Lawn.

Dr. Joseph F. Moriarty then read the following resolution on the death of one of the members of the Society. It was adopted as read:

> Whereas: Dr. Murray David Berk was a loyal and devoted member of the Passaic County Medical Society for over twenty years and
>
> Whereas: he contributed greatly to the Society because of his sincerity and his interest in medicine to which he devoted his life and
>
> Whereas: his services and graciousness made him highly esteemed and respected by his patients, friends and the medical profession and
>
> Whereas: he was a member of the Armed Forces and attained the rank of Colonel in the United States Air Force and devoted many years of service to the Air Force Reserve, therefore
>
> Be It Resolved: that the membership of The Passaic County Medical Society hereby acknowledges its debt to Murray Berk and expresses its profound regret at his untimely death and records this resolution in its minutes, and
>
> Be It Further Resolved: that a copy of this resolution be forwarded to his family.

The President introduced Mr. Edward D. Rohrbach, President of the Passaic County Heart Association. He gave a short, introductory talk on the Meyer Notkin Memorial.

Mr. Rohrbach then called upon Dr. Albert Le May, President of the Medical Board, St. Joseph's Hospital. His topic was "Tribute to Hospital Colleague."

Dr. Le May then turned the meeting over to Dr. David Roth, Chairman, Physician Education Committee of the Passaic County Heart Association. He introduced the guest speaker, Charles K. Friedberg, M.D., Cardiologist to Mount Sinai Hospital, New York. Dr. Friedberg's subject was "Management of Congestive Heart Failure."

At the conclusion of the question period, a collation was served by the Passaic County Heart Association.

DAVID B. LEVINE, M.D.

Reporter

Salem

At the regular monthly meeting of the *Salem County Medical Society* on January 18 at the Du Pont-Penns Grove Country Club, the subject of Professional Liability Insurance was discussed. Chief speaker was Mr. William Deeks, Superintendent of the Underwriting Division of the Philadelphia office of the Aetna Casualty Company. He was introduced by Mr. Joseph Colson, Chairman of the Finance Committee of Salem County Memorial Hospital. Mr. Colson and several members of the society also participated in the discussion. Mr. Deeks explained the types of insurance contracts available to cover the professional liability of individual practitioners, partnerships, and institutions.

The society received progress reports on its program to insure availability of poliomyelitis inoculation. It was urged that the public be informed that the vaccine is now in adequate supply for the inoculation of everyone, both children and adults, and that vaccination should be done immediately to protect against poliomyelitis this summer. The special committee appointed to study methods of administering the vaccine will meet with the Executive Committee soon to outline this year's campaign.

W. L. SPROUT, M.D.

Reporter

Auxiliary Reports • • •

Essex

The Executive Board of the *Woman's Auxiliary to the Essex County Medical Society* met on January 21 at the home of the president, Mrs. Harry DiGiacomo. Half of the pledges received during the first month of the Blood Bank drive donated blood on December 19, 1956, it was announced by Mrs. Franklin Mascia, Chairman of the Auxiliary Committee and Mrs. Anthony Crecca, co-chairman. To date, 34 doctors have pledged a pint of blood for the doctors' bank toward the county goal of 160 pints.

Mrs. Michael Pierce and Mrs. Carlyle W. Schumacher, co-chairmen, announced that 27 Auxiliary members covered the Christmas Seal Booth at Kresge's, Newark, from December 10 through December 22. The proceeds from this effort were $111.34.

Due to the enthusiastic reception at the Poinsettia Ball and an invitation from the State Auxiliary to sing at the convention, Mrs. Harold Grubin is making an earnest appeal for additional members for the choir. Anyone interested should phone Mrs. Grubin at Essex 3-7903.

The regular meeting of the Auxiliary was held on January 28, at 369 Park Avenue, Orange. Mrs. John Insabella arranged a program based on the theme of "Safety." Tea was served.

Mrs. George C. Parell, Chairman of AMEF, announced plans for its annual fund raising event. A dessert-fashion show will be held on February 12 at 369 Park Avenue, Orange. In addition to the fashion show, sponsored by Doop's, East Orange, there will be many other events of interest.

MRS. E. SEIFERT, Chairman

Press and Publicity

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Care of the Long-Term Patient. Published for the Commonwealth Fund by the Harvard University Press. 1956, Cambridge. Pp. 606. ($8.50)

The number one challenge now facing American medicine is care of the long-term patient. Hospitals ought to have as high standards for caring for "chronics" as they insist on in their "acute" services. Doctors should maintain the same unflagging interest in the care of the chronically ill that they show with their more dramatically sick patients. This book is a product of the Commission on Chronic Illness and in thorough, if somewhat unexciting, prose, examines all aspects of the problem. The Commission develops the need for cleaner lines of authority in chronic care programs. It reviews existing and proposed methods for financing such care. It explores ways of maintaining the patient's dignity and respect. It compares home care and hospital care. It discusses defects in existing institutions. It compiles figures on the prevalence of long-term illness. (Estimated number: 5 million.) It makes suggestions about educating the public and the profession about the problem. Altogether this is a solid source book for administrators seriously interested in the subject.

ULYSSES M. FRANK, M.D.

Handbook of Pediatric Emergencies. By Adolph DeSanctis, M.D. with the collaboration of Charles Varga, M.D. 1956 St. Louis. Pp. 389. Mosby. ($6.25)

In this psychosomatic era, many older practitioners devote themselves to the art of medicine, to the neglect of the practical scientific aspect of the profession. These doctors may be embarrassed by inability to recall the instrument used or the dose necessary or even what to do in a "pediatric medical emergency." Here, this book is a godsend. It sets forth in concise outline methods of treating pediatric emergencies, affords excellent and convenient means of helping to handle the sometimes frustrating experiences emergencies create for the pediatrician. Dr. DeSanctis covers emergencies of the major organic systems; cardiovascular, metabolic, genito-urinary, neurologic and respiratory. The remaining chapters deal with premature care, drowning, poisoning and other accident preventions and care. A large, and excellently illustrated section is devoted to pediatric procedures such as venesection, clysis and subdural tap. Some of the emergencies are: convulsions, croup, craniocerebral injuries, dehydration, asthma, cardiac failure, respiratory paralysis, newborn resuscitation, vomiting, diarrhea and diabetic coma. The

proper course of action is precisely described and this is tied to a description of signs and symptoms accompanying each emergency.

Particularly valuable is the discussion of the correction of electrolyte disturbances with its simple way of computing fluid replacement by determining surface area of body. If he has this book, the attending pediatrician will not have to depend on his residents for information about amounts and doses, material which the resident usually carries in a little notebook.

RALPH N. SHAPIRO, M.D.

The Patient Speaks. Harold A. Abramson, M.D. Pp. 239, New York, 1956, Vantage Press. ($3.50)

This book seems aimed at two problems. One is to familiarize the layman with psychoanalytic psychotherapy. This is accomplished reasonably well despite the obvious omission of all material not directly involving the patient's relationship to the mother. On the other hand, very few statements by the therapist are recorded, which makes it difficult to perceive the therapist-patient relationship and its relation to the progress displayed by the patient. Also for this purpose the first and last chapters embody the technical language that is likely to be cumbersome to the lay reader. These comments seem more aimed at the professional reader, for whom Dr. Abramson intends to touch on the second problem, which is to find a better means of reporting the treatment process. In addition, he demonstrates a particular mother-child relation, identified as the Cronus complex, in which the mother threatens to engulf the child and make all decisions for him. As a method of case reporting this is of interest. But the book leaves so many questions about treatment dynamics that it seems to me to bring us no closer to the answer to one of psychiatry's big problems. As a presentation of the Cronus complex, you will find a parent type delineated that is well worth considering if you have not faced it before hearing this name for it.

JAY W. FIDLER, M.D.

From Medicine Man to Freud: An Anthology. Edited with notes by Jan Ehrenwald, M.D. New York 1957. Dell. Paper bound. Pp. 416. ($0.50)

For the nominal sum of 50 cents you can own this fat source book of psychological medicine. Dr. Ehrenwald has collected fragments of original documents reflecting first thinking in the subject: fragments from the Golden Bough and from *Malleus Malleficarium*: selections from Pinel and selections from Freud; original paragraphs by Mesmer and others written by Hippocrates — and so on from ancient Babylonian tablets to yesterday's writing by Fromm and by Jones. Dr. Ehrenwald's own notes are brief, dry, and pedestrian. As with all anthologies, the quality of writing—and of readability—varies. In many cases, a modern paraphrase would have been easier to understand than the classical language of the original. The motley collection produces a jerky picture of the march of psychiatry. The editor had to sacrifice smoothness and integration for the virtue of citing the pure originals. The serious student of medicine will want this to dip into to verify a reference, to do his own interpreting and to get the sense of historical perspective. It is no substitute for the more readable histories of medicine in general, psychiatry in particular. But it is a unique documentary of one of medicine's most significant and exciting fields.

HERBERT BOEHM, M.D.

The Official American Medical Association Book of Health. Edited by W. W. Bauer, M.D. New York 1957. Pp. 320. Paper. Dell Publishing Company. ($0.35)

The absence of an index makes this book useless for reference purposes. If you want your patient to read something on sinuses, anxiety reaction or gout, he won't be able to find the item since there is no index. An unsophisticated reader will have trouble wending his way through the table of contents. The book is made up of articles previously published in *Today's Health* and, like all anthologies is very varied. Some items are good, some are sketchy, some are fatuously overoptimistic. The articles are authoritative in that they are written by qualified specialists or by newspaper or magazine writers under medical supervision. This is a useful manual for the patient.

VICTOR HUBERMAN, M.D.

The Philosophy of Medicine. William Laird, M.D. Charleston, West Virginia 1957. Education Foundation, Inc. Pp. 64. No index. ($3.00)

In his foreword, Dr. Laird sagely remarks that "this is not a book and is not intended for a book." It is a collection of informal personal remarks on medical and surgical practice, printed on a fine rag paper, beautifully bound into a 64 page book selling for $3.00. The first chapter is on logic. Example: "Specific ability in applying the principles of logic is needed in diagnosis and treatment." The second chapter is entitled "Esthetics." Thus, "The physician who can bring to his patient a sympathetic knowledge of beauty and art contributes inestimably to his well-being." The third chapter is on ethics. "Management should be the same for private and so-called charity patients." The chapter on politics discusses the physician's duties to the community. At the end Dr. Laird suggests that the physician should be both scientist and metaphysician.

HENRY A. DAVIDSON, M.D.

TUBERCULOSIS *Abstracts*

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VOL. XXX March, 1957 No. 3

GENERAL HOSPITAL ADMISSION X-RAYS

By James M. Blake, M.D., and Kencil L. Mitton, M.D., New York State Journal of Medicine, October, 1956.

● A review of the admission x-ray program at Ellis Hospital (Schenectady, New York) demonstrated the value of this procedure. Admission chest x-rays should be routine in general hospitals since they aid in discovering more unknown disease than other routine admission examinations. The value of admission x-rays to the physician is in direct relationship to utilization and interest. The follow-up study is an important part of the program.

The discovery and isolation of the unknown cases of tuberculosis has been and continues to be the primary objective in the control of this disease. This objective will become increasingly important as the death rate and morbidity rate decline.

The population may be divided into four groups for the purpose of detecting significant cases of tuberculosis:

1. Those patients who visit their physicians because of symptoms of disease in the lungs. This is by far the most important group not only because of the higher incidence of tuberculosis among them, but also because if tuberculosis is the cause of their symptoms, they already are spreaders of the disease.

2. Patients admitted to general hospitals. The symptoms of pulmonary disease and the presence of disease in the lungs may or may not have been the reason for admission to the hospital. The presence of pulmonary disease may merely have been coincidental. These individuals are frequently symptomatic and under the observation of a physician. They are second in importance to the first group only from the point of view of classification.

3. Those individuals who have close contact with a known case of active tuberculosis.

4. The apparently healthy individuals.

This discussion is concerned with the routine admissions to general hospitals. Group studies on the prevalence of tuberculosis in general hospital admissions up to within the last two years have shown x-ray evidence of tuberculosis in from 2.8 to 8.1 per cent of the patients admitted. Of this group the presence of active tuberculosis has varied from 0.6 to 1.8 per cent. These studies have shown further that active tuberculosis in individuals x-rayed on admission to general hospitals has been from two to six times as productive in the yield of significant tuberculosis as have other types of mass x-ray examination.

The detection of infectious, active tuberculosis and the isolation of the patient in the general hospital is of significance from many points of view. The protection of the hospital personnel by the proper isolation of the patient is obvious. The contributions to the care of the patient in the demonstration and discovery not only of tuberculosis but of nontuberculous diseases of the chest and cardiovascular system are also important. The admission x-ray is of greater value than are many other routine laboratory procedures. It has been demonstrated in various studies that clinically significant abnormalities of the chest are found in from 10 to 15 per cent of all patients examined.

The normal practice of most physicians today is based on routine examinations. Blood count, urinalysis, Wassermann, history, and physical examinations are basic procedures in evaluating the patient's problem. The admission chest x-ray has become a part of the program of more progressive general hospitals. One might say another routine examination is provided the patient and the physician as part of the first day's admission fee.

The significance and the value of the admission x-ray to the physician is in direct relationship to his utilization and interest. It is not infrequent to observe patients having multiple examinations to determine the diagnosis when the answer is photographically inscribed on the photoroentgenogram on the back of the chart.

There perhaps has been some reluctance in reference to the photoroentgenogram x-ray, based on opinions that the so-called small film is not entirely satisfactory for diagnosis. Certainly, one would not wish to make a final evaluation based on the small x-ray, but the error is usually on the side of safety. The value of an x-ray examination is limited entirely to the interpretation which is placed on the shadows in that x-ray and the aid they give in guidance to other examinations and treatments.

The admission x-ray program at the Ellis Hospital was one of the earliest established in New York State, having been instituted in 1947. A comparative study between the first full year of operation of this program and the last completed year of service, 1948 to 1954 is shown in Tables I and II.

TABLE I.—Ellis Hospital Admission X-rays

	Year	
	1948	1954
Number of adult admissions	11,487	11,281
Number of admissions x-rayed	8,734	8,641
Per cent of admissions x-rayed	76	76
Total x-rays	11,039	11,621
Diagnosis of admission x-rays by x-ray dept.		
Total abnormal diagnoses		
Number	1,599	1,452
Per cent	14.4	12.4
Total nontuberculous diagnoses		
Number	1,259	1,248
Per cent	11.4	10.7
Total active tuberculosis diagnoses		
Number	158	82
Per cent	1.4	0.70
Total inactive tuberculosis diagnoses		
Number	182	122
Per cent	1.6	1.04

These comparative statistics would seem to confirm observations of the declining incidences of tuberculosis. It is hoped that this tendency will continue until the disease is no longer of major concern. However, until the problem of immunity in tuberculosis is solved, the search for persons with unknown tuberculosis and the supervision of spreaders of tuberculosis will continue to be the safeguard for keeping the death rate and the morbidity rate at a minimum.

The discovery of tuberculosis in mass surveys of the general population, in contrast to selected groups such as general hospital admissions, calls for the examination of more and more individuals

TABLE II.—Follow-up Study of Admissions Diagnosed Active and Inactive Tuberculosis in Relation to Total Number X-rayed

Diagnosis	Year	
	1948	1954
	ACTIVE TUBERCULOSIS	
Active tuberculosis		
Number	40	4
Per cent of total x-rayed	0.35	0.03
Inactive tuberculosis		
Number	35	8
Per cent of total x-rayed	0.32	0.06
	INACTIVE TUBERCULOSIS	
Active tuberculosis		
Number	2	1
Per cent of total x-rayed	0.01	0.008
Inactive tuberculosis		
Number	126	61
Per cent of total x-rayed	1.14	0.52

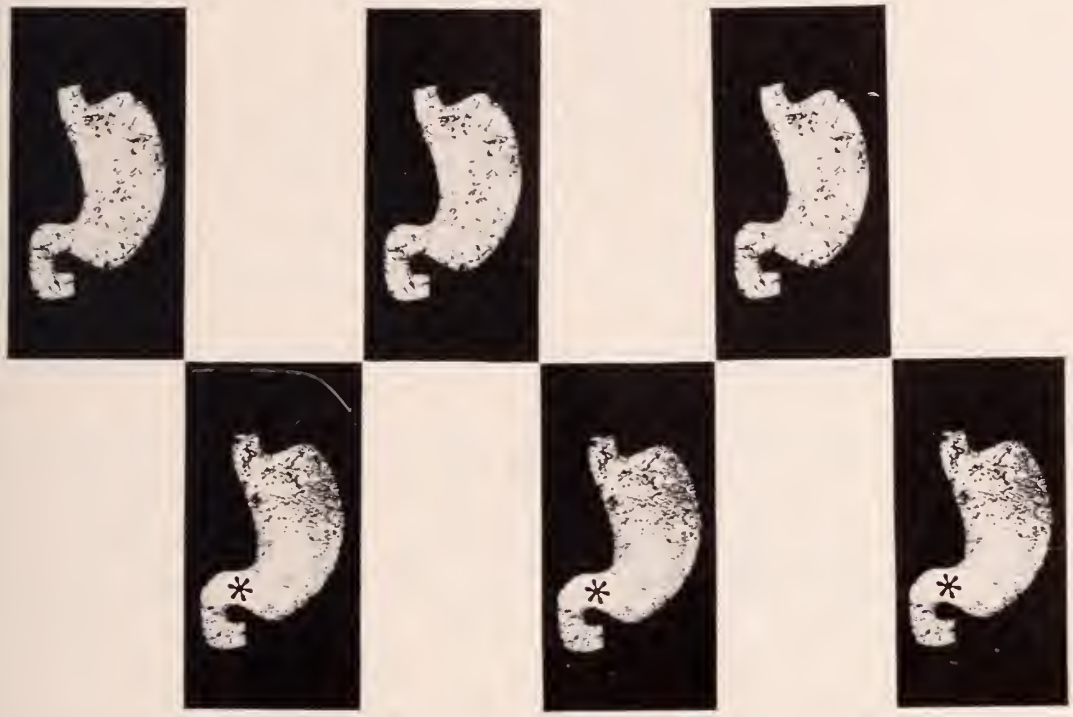
to find a single case of significant tuberculosis. This has reached the point today of almost insignificant yield. The search for tuberculosis in the future must be more selective than it has been in the past. As the incidence of tuberculosis declines and ambulant treatment of tuberculosis increases, the responsibility of the family physician in the control of tuberculosis becomes greater. Likewise, the general hospital will have to assume greater responsibility for this program in its community.

The follow-up study of tuberculosis and other diseases of the lungs detected by such examinations is perhaps the most important phase of the program. The patients involved are under the care of their family physicians and he is responsible for the follow-up study. More and more hospitals are accepting chest x-ray programs as an established procedure which has significance both to the physician and to the patient in arriving at a diagnosis. A serious argument for the establishment of such programs is the physician's responsibility for follow-up evaluation. This is particularly important when the growing rate of malpractice suits is considered.

Failure to use the x-ray at all, or failure to make sufficient use of the x-ray, has been the chief allegation in many malpractice actions. It seems reasonable, therefore, to point out that failure to give routine x-ray on hospital admissions may in the not too distant future be considered negligence.

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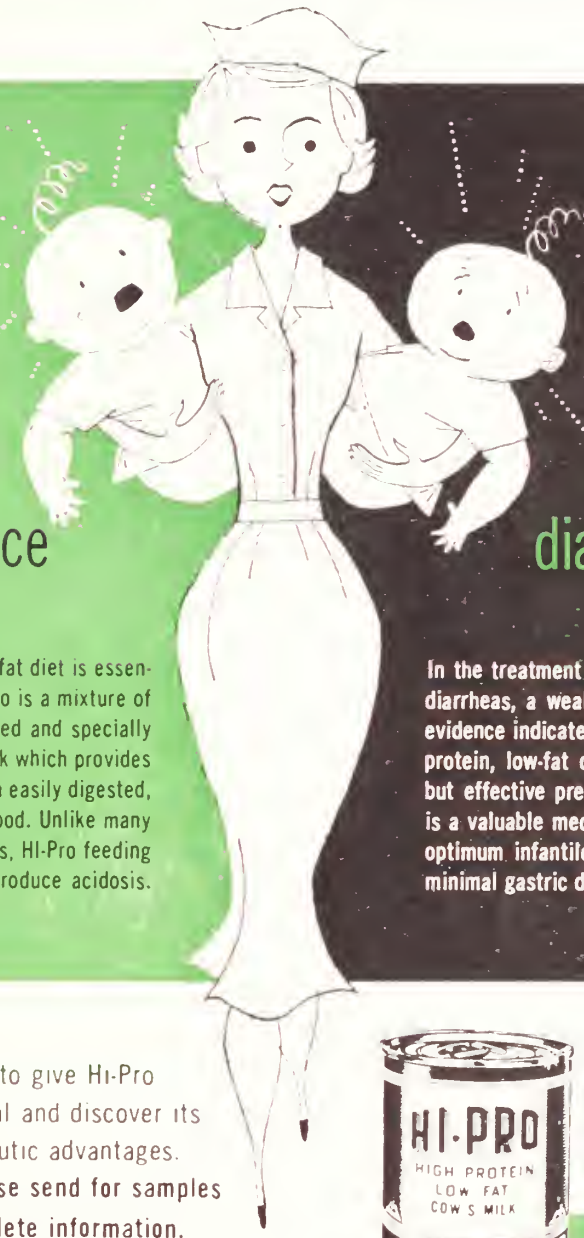
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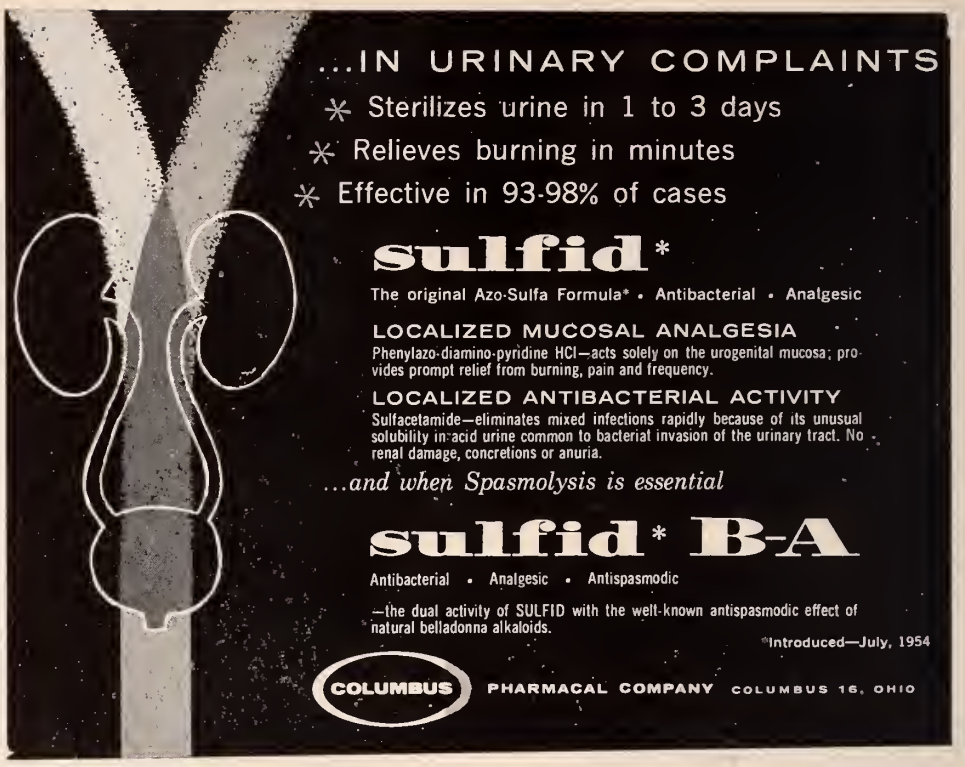
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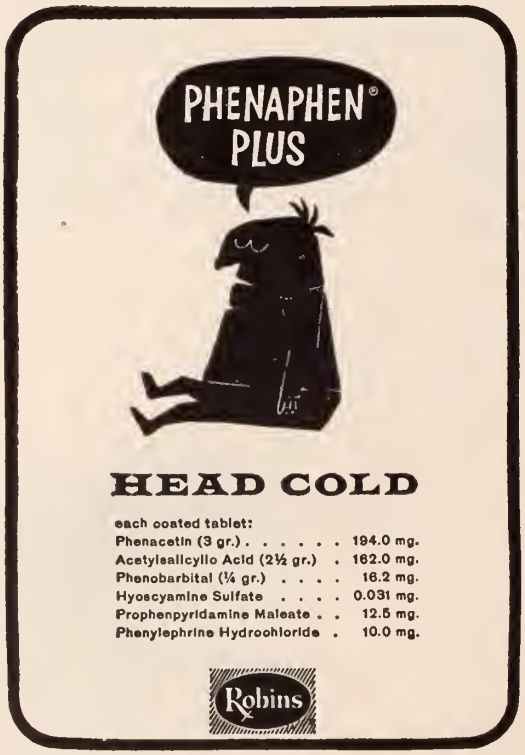
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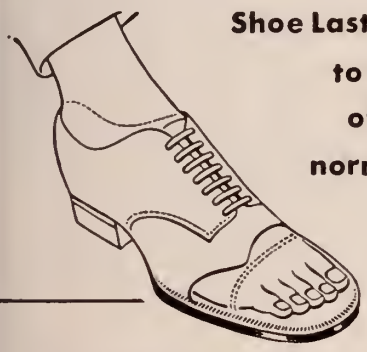
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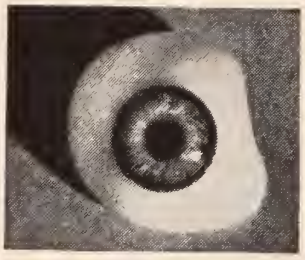
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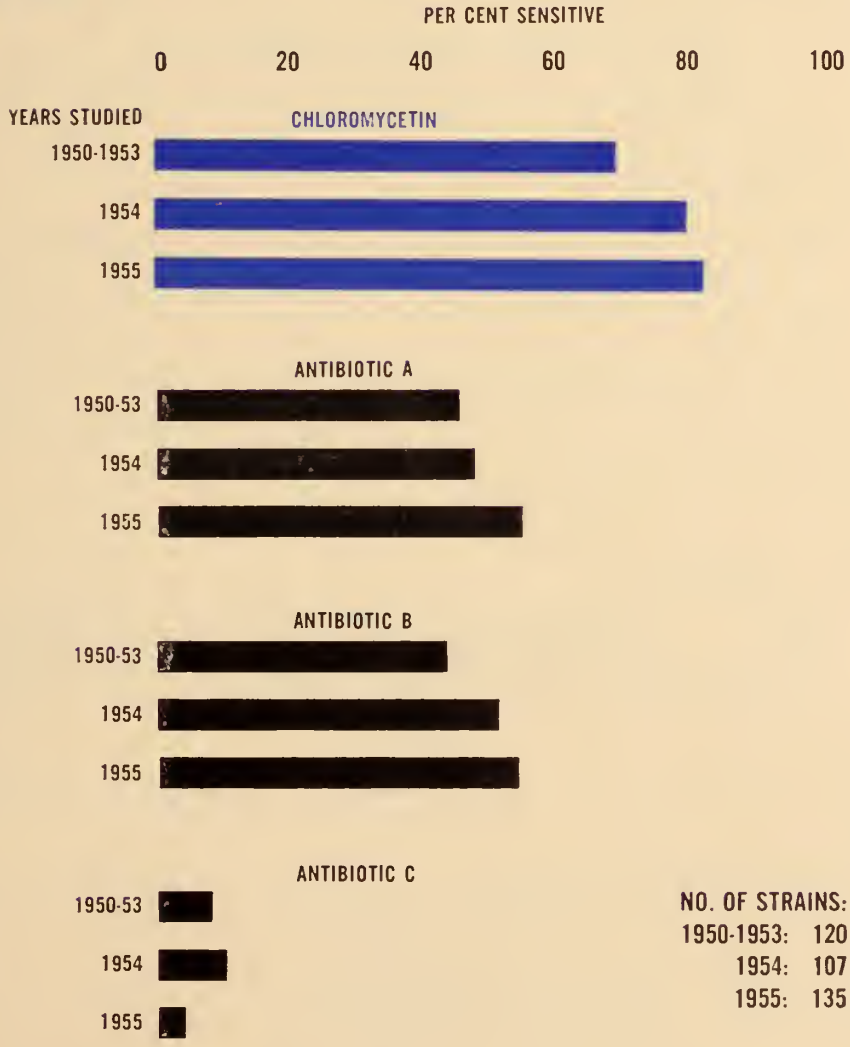
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J. Wallace Hurff (1958) ..... Newark
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Elmer P. Weigel (1958) ..... Plainfield

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Albert B. Kump (1957) ..... Bridgeton
Elton W. Lance (1957) ..... Rahway
Jesse McCall (1958) ..... Newton
Herschel Pettit (1958) ..... Ocean City
John H. Rowland (1958) ..... New Brunswick

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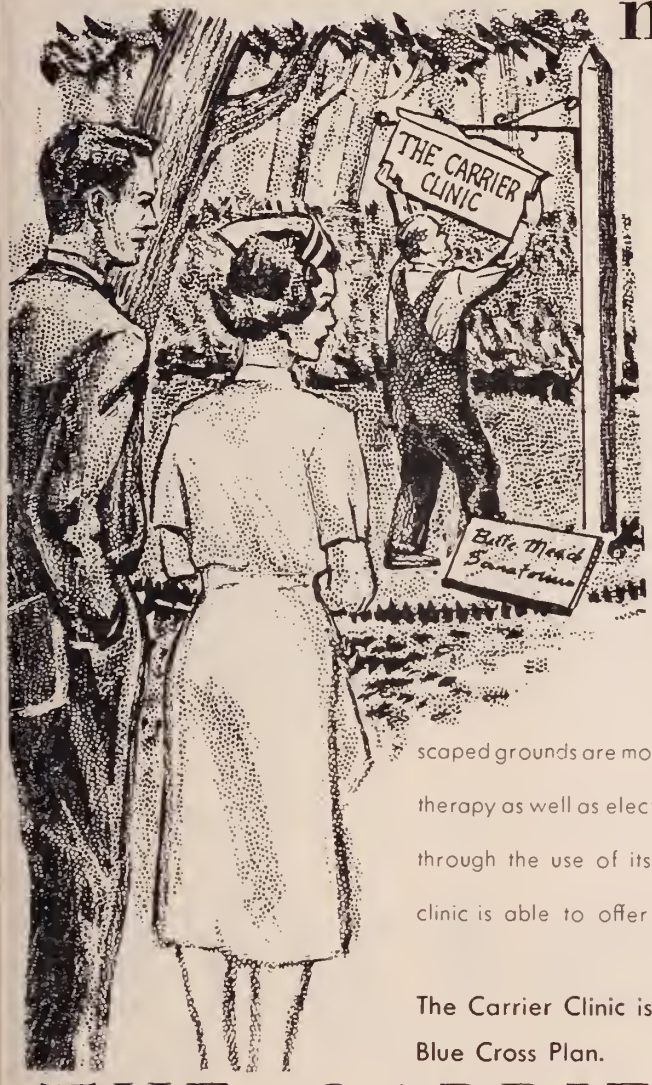
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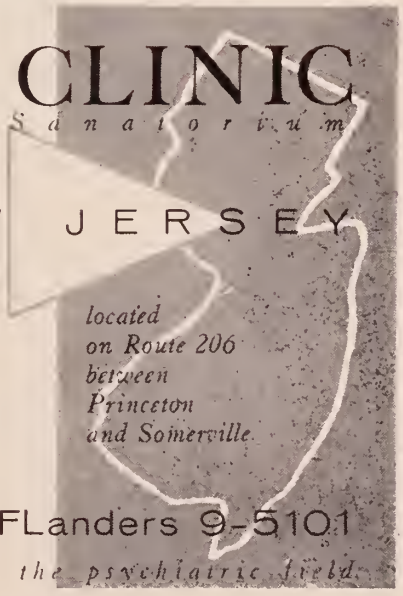
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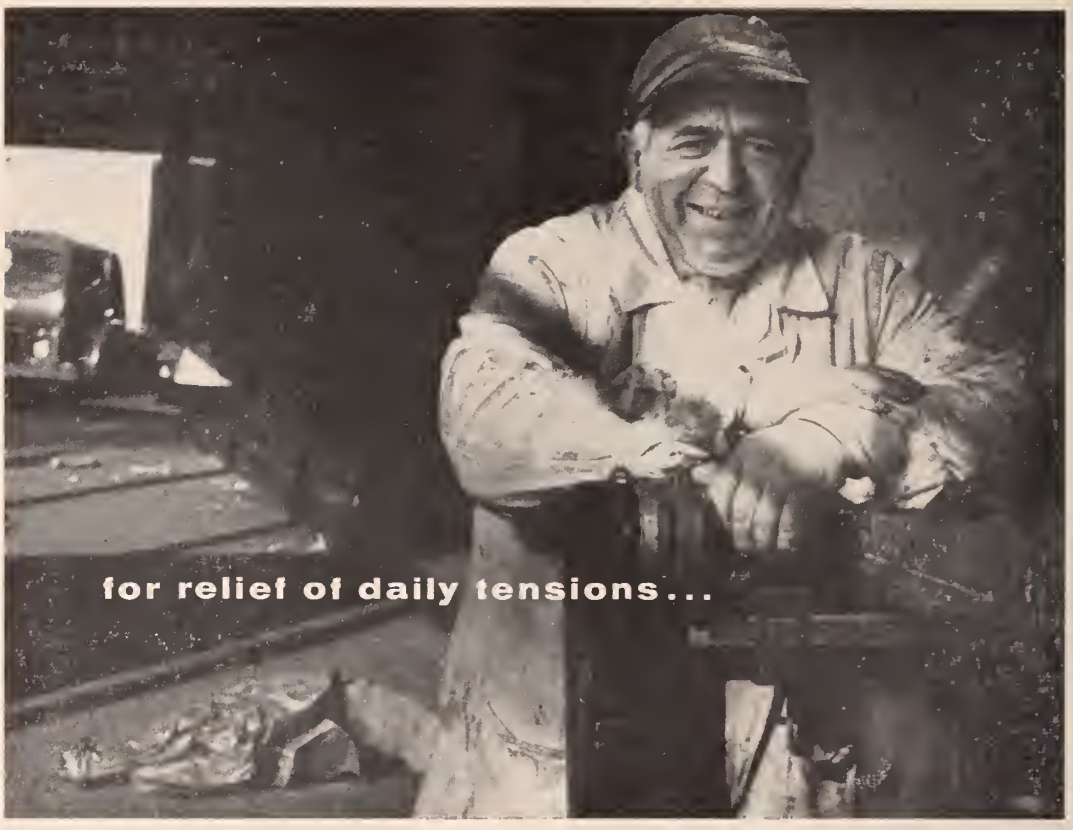
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*Ferguson, J. T.: J. Am. Geriatrics Soc. *4*:1080, 1956.

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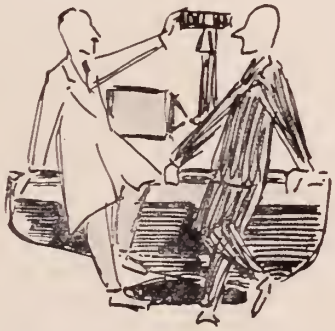
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"Tom" had tuberculosis. And in this latest Parke-Davis message on the cost of medical care, "Tom's case" is used as a specific example of the heartening progress being made against sickness and disease.

The ad points out that, thanks to earlier detection, improved surgery and the anti-tuberculosis drugs, tuberculosis has fallen from first to sixth place among the ten leading causes of death.

Unfortunately, most people do not appreciate the priceless value of today's more effective medical care until they come face to face with a dread disease—like "Tom". And that's why, with a colorful new series of advertisements,* Parke-Davis is helping to give your patients a new and clearer understanding of what modern medical care can do for them—in terms of getting them well quicker, back on the job again, and even saving their lives.

In short, we're continuing to tell your patients that prompt and proper medical care may well turn out to be the biggest bargain ever to come their way.

PARKE, DAVIS & COMPANY

Detroit 32, Michigan

* *Now in eye-catching color in* LIFE, TIME, SATURDAY EVENING POST *and* TODAY'S HEALTH.

TIME * LIFE * TODAY'S HEALTH * POST

NEW...



Each Multiple Compressed Tablet of MEPROLONE provides the inseparable antiarthritic, antirheumatic benefits of:

1. *Prednisolone buffered*—the newest and most potent of the "predni-steroids" for prompt relief of joint pain and arrest of the destructive inflammatory process.

2. *Meprobamate*—the newest and safest of the muscle-relaxant tranquilizers for profound relaxation of skeletal muscle in spasm.

Tolerance to this combination is good because there is little likelihood of sodium retention, potassium depletion or gastric distress with buffered prednisolone, and meprobamate rarely produces significant side effects in therapeutic dosage.

An additional important therapeutic benefit, often overlooked, stems from the tranquilizing action of meprobamate. This component of MEPROLONE relieves mental tension and anxiety so often manifest in arthritics, making them more amenable to other rehabilitation measures.

INDICATIONS: A wide variety of conditions, in which four symptoms predominate: *a*) inflammation *b*) muscle spasm *c*) anxiety and tension *d*) discomfort and disability; i.e., rheumatoid arthritis, rheumatoid spondylitis (Marie-Strümpell disease), Still's disease, psoriatic arthritis, osteo-

Therapeutic benefits of MEPROLONE compared with tradit

	relieves pain	suppresses inflam-mation	relaxes muscle	eas anxi
Salicylates	✓	✓		
Muscle relaxants			✓1	
Tranquilizers				✓
Steroids	✓	✓		
MEPROLONE	✓	✓	✓	✓

1. Meprobamate is the only tran muscle-rel

arthritis, bursitis, synovitis, tenosynovitis, n sitis, fibromyositis, neuritis, acute and chr pain, acute and chronic primary and secon and torticollis, intractable asthma, respira allergic and inflammatory eye and skin disor tenance therapy in disseminated lupus e periarteritis nodosa, dermatomyositis and

SUPPLIED: Multiple Compressed Tablet 100 in two formulas as follows: MEPROLO of prednisolone, 200 mg. of meprobamate a dried aluminum hydroxide gel. MEPROLON 2.0 mg. of prednisolone in the same formu

NO OTHER

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PRODUCT

PROVIDES AS MANY

BENEFITS AS

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MEPRO | BAMATE
PREDNISO | LONE, *buffered*

THE ONLY

ANTIRHEUMATIC,

ANTIARTHRITIC

THAT SIMULTANEOUSLY

RELIEVES:

1. MUSCLE SPASM
2. JOINT INFLAMMATION
3. ANXIETY AND TENSION
4. DISCOMFORT AND DISABILITY

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DIVISION OF MERCK & CO., INC. PHILADELPHIA 1, PA.

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Hope alone remained. To the allergic patient,
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'Perazil' offers far more than hope. It gives
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long-lasting action • exceptionally little side effect

For children and adults: SUGAR-COATED TABLETS OF 25 mg.
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COLLOIDAL EMULSION OF MINERAL OIL AND IRISH MOSS

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KONDREMUL *(Plain)*—Pleasant-tasting and non-habit-forming. Contains 55% mineral oil. Supplied in bottles of 1 pt.

KONDREMUL *(With Cascara)*—0.66 Gm. nonbitter Ext. Cascara per tablespoon. Bottles of 14 fl.oz.

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When taken as directed before retiring, KONDREMUL does not interfere with absorption of essential nutrients.

THE E. L. PATCH CO. — STONEHAM, MASSACHUSETTS



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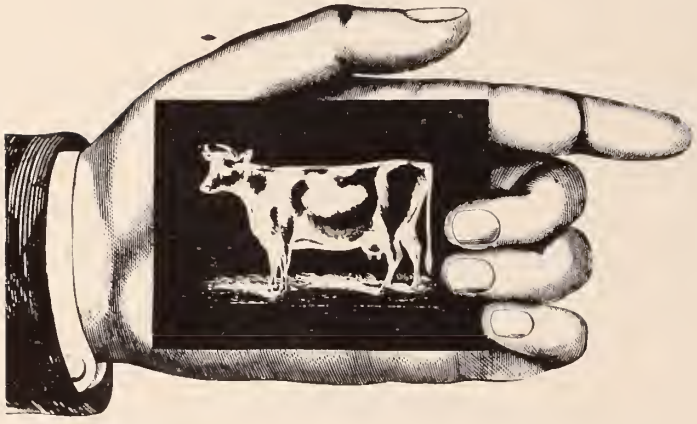
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prevents nausea,
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HI-PRO provides a full quota of calories without danger of fat irritation in cases of fat intolerance or where digestive disturbances are present. Readily digestible, it is ideal in treatment of infant diarrhea, prematures, fat intolerance and normal newborns.

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Proteins are well-absorbed and supply calories lost by reduction in fat and carbohydrates.

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Rapid growth plus low fat tolerance makes HI-PRO an ideal food.

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Protein is well-absorbed and caloric intake can be raised to any level without fat difficulties.

normal newborns
With HI-PRO, you can provide extra protein without fat for rapid growth and good tissue turgor.

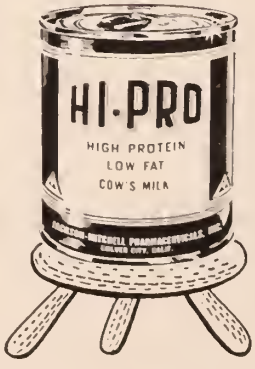
hi-pro, analysis — dry

Protein	41%
Fat	14%
Carbohydrate	35%
Calcium	1.15%
Calories per oz.	121



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HI-PRO is available in 1-lb. and 2½-lb. vacuum-packed tins at all pharmacies.



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"No more a stranger to my family—thanks to the **VOICEWRITER**"

"I'm a pediatrician—but the kids I used to see the least—were my own.

"We're becoming buddies now, though . . . because three months ago I got an Edison Voicewriter.

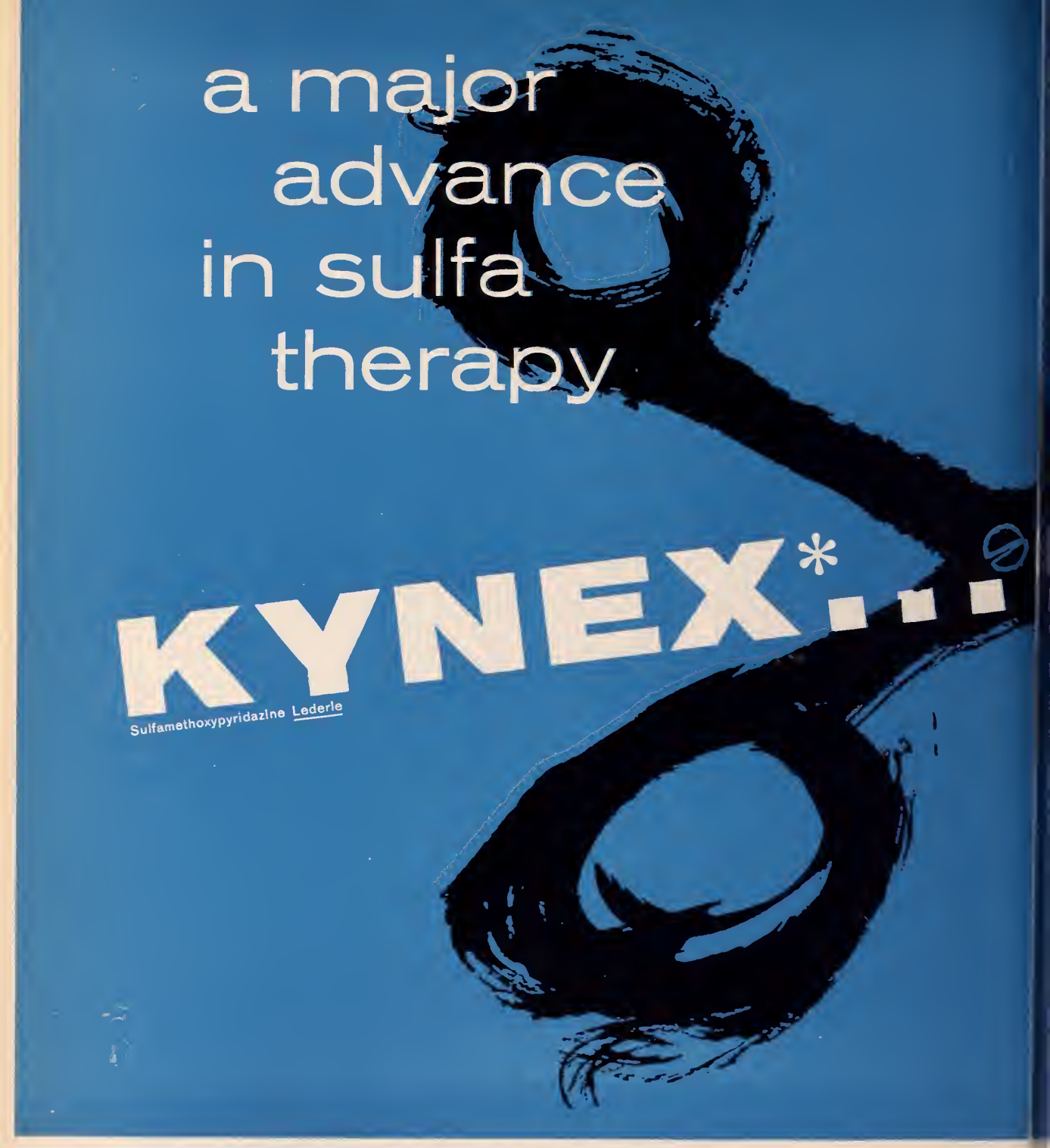
"The Voicewriter saves me hours of time. Helps me quickly bring case histories up-to-date. I take it with me in the car—dictate my patient report after making each call. It's three times faster . . . and my case histories are more complete, more valuable—because they're done while the facts are fresh!"

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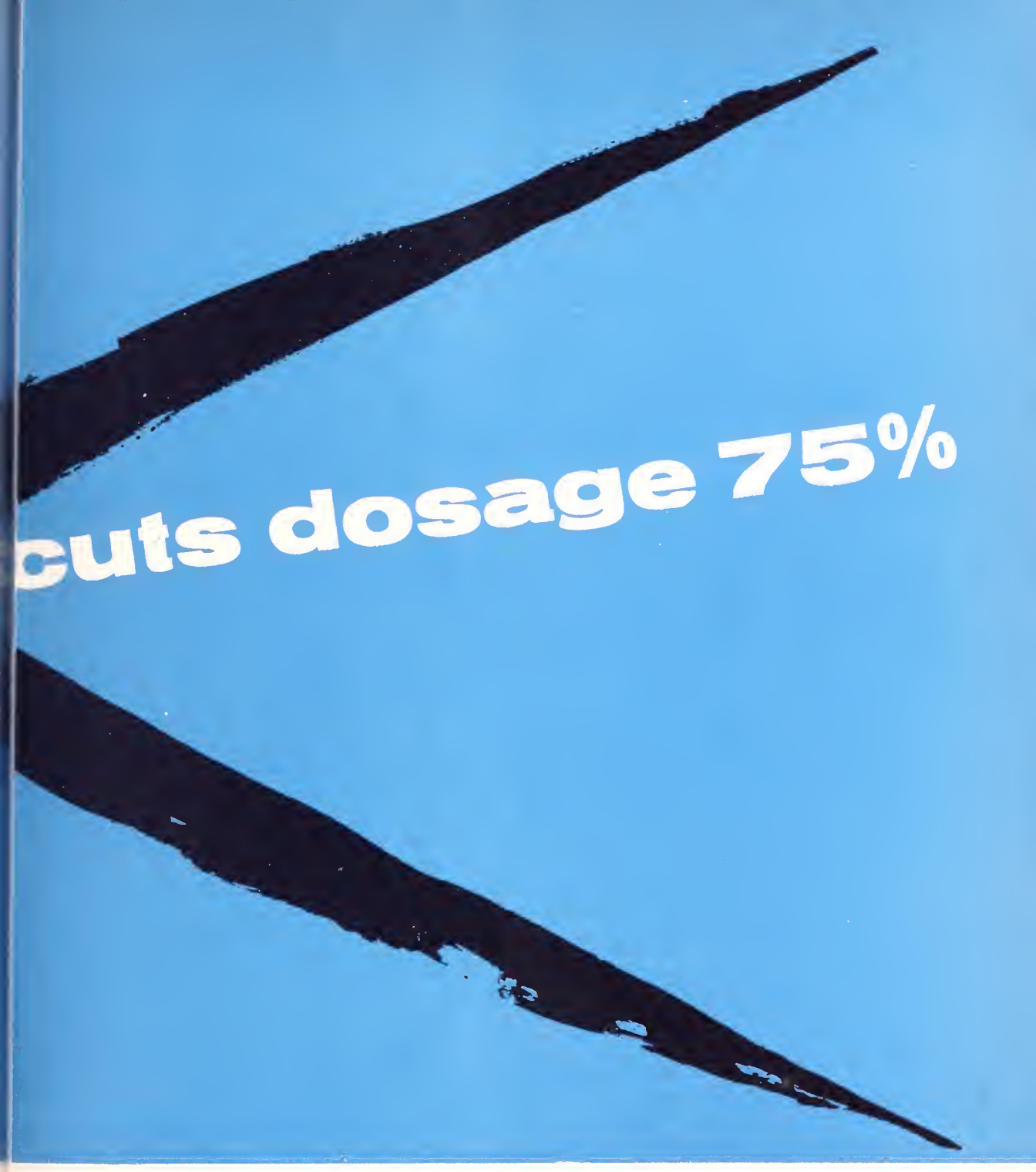
KYNEX is an entirely new, readily soluble, single sulfonamide exhibiting excellent antibacterial action at radicall reduced dosage.

KYNEX offers desirable clinical advantages hitherto not obtained by any related drug—

LOW DOSAGE: a total maintenance dose of only 2 tablets daily.

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CONVENIENCE: The low dose of 1 Gm. (2 tablets) per day offers optimal convenience and acceptance to patients.

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unexcelled in
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(phenylbutazone GEIGY)

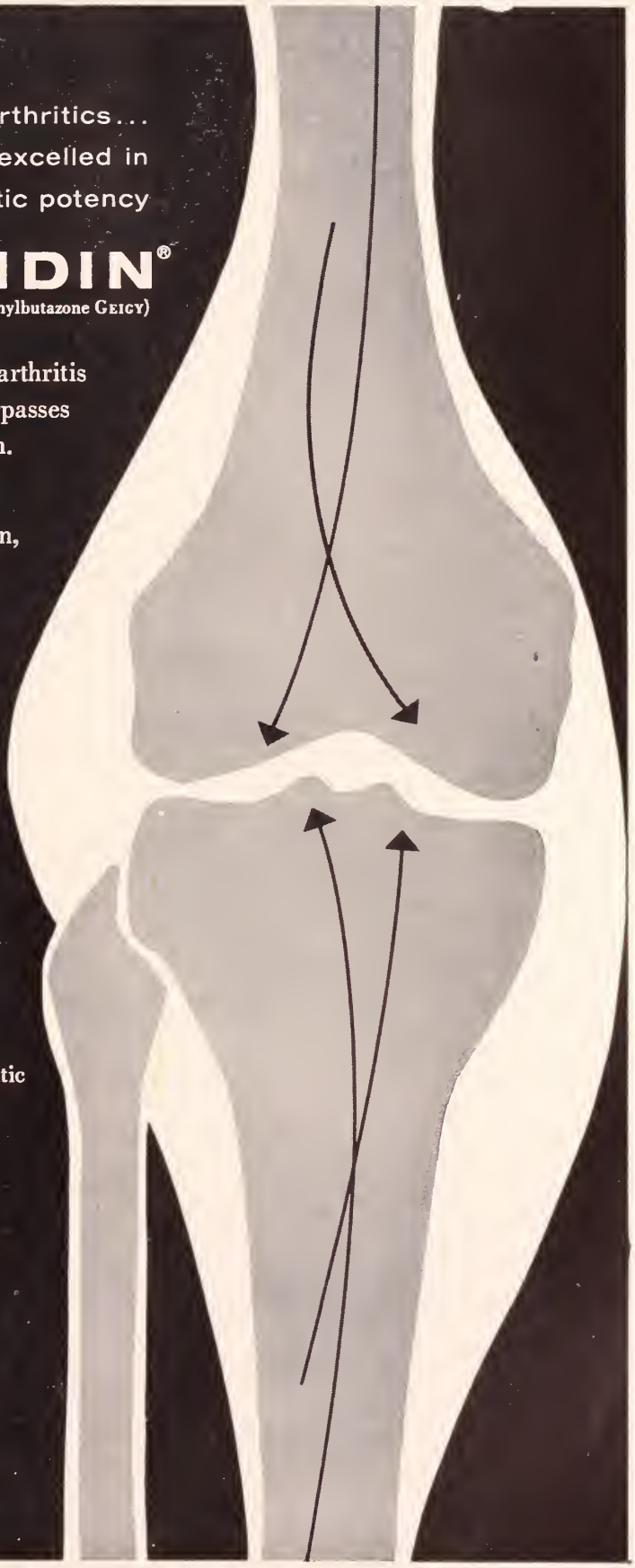
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Its well-established advantages include remarkably prompt action, broad scope of usefulness, and no tendency to development of drug tolerance. Being nonhormonal, BUTAZOLIDIN causes no upset of normal endocrine balance.

BUTAZOLIDIN relieves pain, improves function, resolves inflammation in:
Gouty Arthritis
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BUTAZOLIDIN being a potent therapeutic agent, physicians unfamiliar with its use are urged to send for detailed literature before instituting therapy.

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SAY "BREE-OS-KEE"

THE PLEASANT

ANTI-ACID

At all druggists

Actively alkaline. Contains no narcotics, no injurious drugs. Consists of alkali salts, fruit acids, and sugar, and makes a pleasant effervescent drink

SEND FOR A SAMPLE.

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HIGH FIDELITY
SYSTEMS and
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relieves the discomfort of colds

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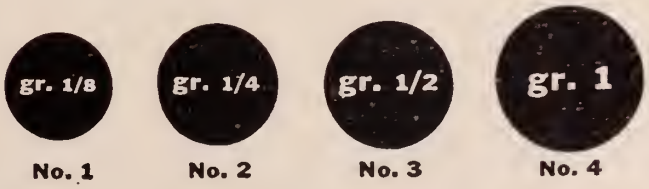
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These are the busiest of times—when a professional man must crowd the fullest measure of activity into every hour of the twenty-four.

And how wonderful it is to be able to spend a part of every day in the driver's seat of a new 1957 Cadillac.

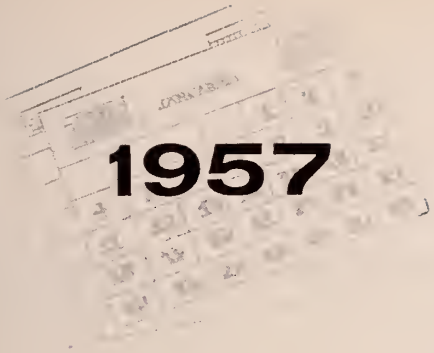
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To begin with, the car is wonderfully comfortable . . . with its deep, soft cushions and its generous interior dimensions. How quiet it is . . . with only the soft sound of the passing wind to lend a sense of motion. And how restful and relaxing it is to drive . . . with its perfect poise and its marvelous ease of handling.

We sincerely urge you to visit us soon—take the wheel—and discover how an hour in the "car of cars" can put a new light on the day.

We think you'll quickly see the wisdom of making *your* daily rounds in a Cadillac of your own!

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now the new **phosphate complex** of tetracycline

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the broad **clinical** spectrum of SUMYCIN against pathogenic organisms



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BABY SERVICE HAS CREATED AN OUTSTANDING HOSPITAL SERVICE DIVISION

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Mom "wears
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frozen shoulder

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for patients who go beyond their physical capacity

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• Dannon Yogurt provides a delicious, palatable source of protein-mineral supply; it is low in calories (50% butter fat removed), a natural, good-tasting food supplement, smooth as custard, in several palate-tested flavors... plain, orange, strawberry, vanilla and prune whip. Simply excellent for all ages.

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try it, doctor...

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Ferrer, F. P., and Boyd, L. J.: Am. J. Dig. Dis., 22:272, 1955
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In Feeding Prematures

Recent metabolic studies have established rational feeding procedures for prematures.

The initial feeding, 12 hours after birth, consists of one dram of 5 per cent dextrose. This solution is increased by one dram at 2-hour intervals if tolerated and retained.

After twenty-four hours, breast milk or formula (table below) gradually replaces the prelacteal feeding at 2-hour intervals. The volume of a feeding may be increased up to 2 drams daily until maintenance caloric requirements are fulfilled by the fifth day. If the infant shows signs of intolerance, the formula increase is made more slowly and the fluid requirement fulfilled parenterally.

Successful feeding mixtures consist of dilutions of powdered half-skimmed or evaporated whole cow's milk, skimmed or whole lactic acid milk. These formulas contain high protein, moderate carbohydrate and low fat, yielding about 120 calories and 150 cc. fluid per kgm. body weight.

The problems of prematures are always the same but the solutions differ with each era. Today the moderate carbohydrate requirement for normal infants as well as prematures is fulfilled by KARO® Syrup as adequately as a generation ago. Whatever the type of milk adapted to the infant, KARO may be added confidently because it is a balanced mixture of lower sugars resistant to fermentation, non-laxative, easily assimilated and well tolerated by all infants.

Readily available in all food stores.

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℞ FIRST FORMULAS FOR PREMATURES

Fresh or whole lactic acid milk	6 oz.
Water	12 oz.
KARO	1 oz.
Evaporated milk	3 oz.
Water	15 oz.
KARO	1 oz.
Dried milk (half-skimmed)	4 tbsp.
Water	18 oz.
KARO	1 oz.

Feedings: 1½ oz. x 12 x 2 hours

Measures: 1 oz. KARO = 2 tablespoons

Caloric values: KARO, 120 per oz.; Cow's milk, 20 per oz.; Evaporated milk, 45 per oz.; Dried milk (½ skimmed), 35 per oz. (Val.).

Equivalents: Red Label KARO or Blue Label KARO may be used interchangeably in all formulas.

Adapted from Nelson's Pediatrics, Saunders, Phila. 1954



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trichotine*

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1. *Trichotine is a detergent*
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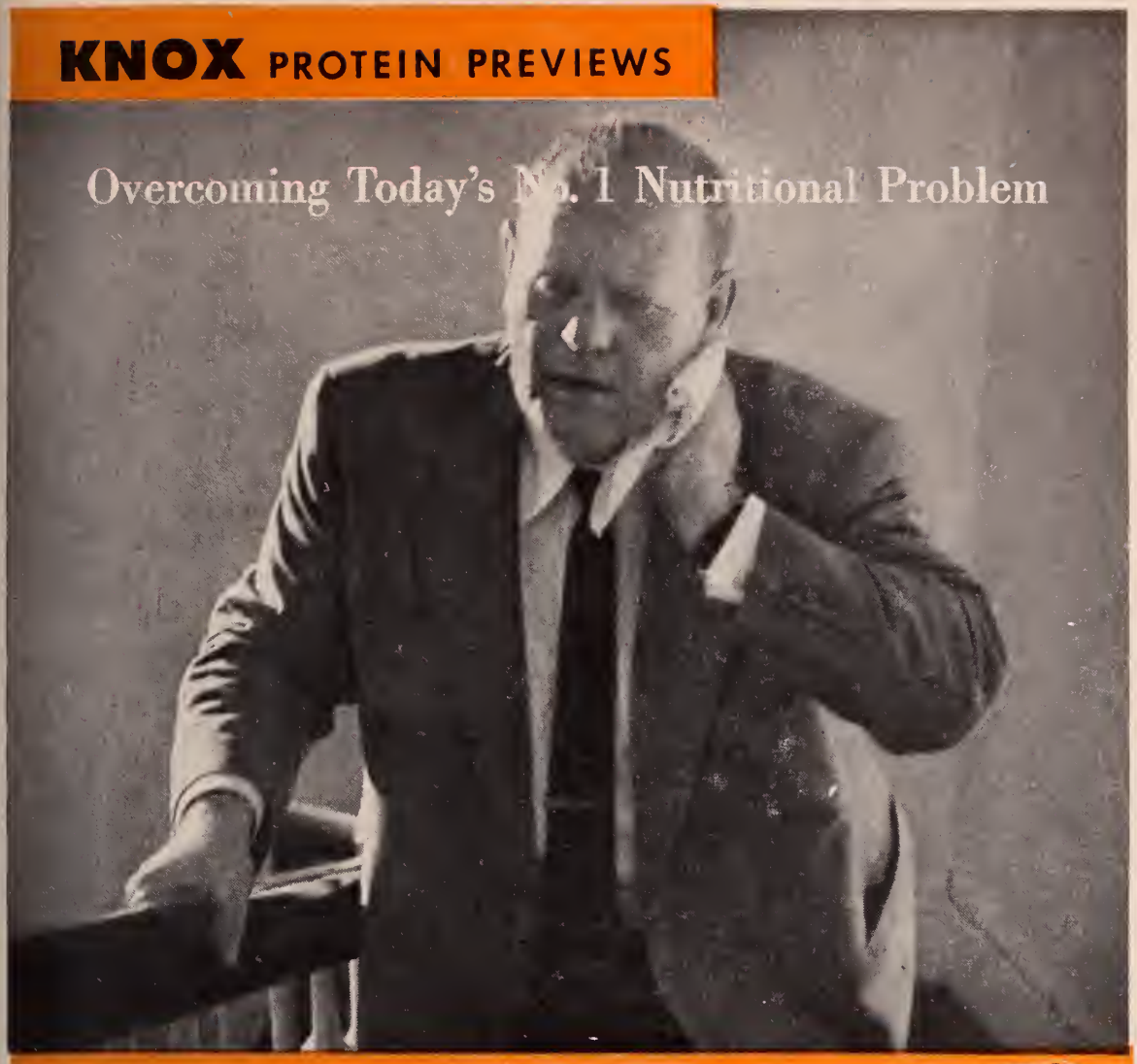
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1. Color-coded diets of 1200, 1600 and 1800 calories are based on nutritionally-sound Food Exchanges.[1]

2. Easy-to-use Food Exchanges (referred to in the Knox booklet as Choices) eliminate calorie counting by patient.

3. Diets promote accurate adjustment of caloric levels to the special needs of the patient yet allow each individual considerable latitude in the choice of foods.

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1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc., and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.



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Please send me ..... dozen copies of the new illustrated Knox Reducing booklet based on Food Exchanges.

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3½ YEARS OF
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CORTROPHIN*-ZINC†

Look in your mail
for the series of ACTH
reviews written expressly
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Supplied in 5-cc vials, each cc containing 40 U.S.P. units of corticotropin with zinc hydroxide (2.0 mg of zinc) for repository action.

[1]*Spies, T. D., J. A. M. A., 153:185, 1953.*
[2]*References supplied on request.*
**T.M.— Cortrophin*
†*Patent Pending. Available in other countries as Cortrophine-Z.*

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the original tranquilizer-corticoid

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advantages: (1) greater flexibility of dosage (2) effective tranquilization permits lower corticoid dosage

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Dihydrocodeinone bitartrate	1.33 mg.
Potassium guaiacol sulfonate	70.0 mg.
Ammonium chloride	70.0 mg.
Menthol	1.0 mg.
Chloroform	0.02 cc.
Alcohol	8%

Bottles of 16 fl. oz.

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Serpate
(Reserpine)
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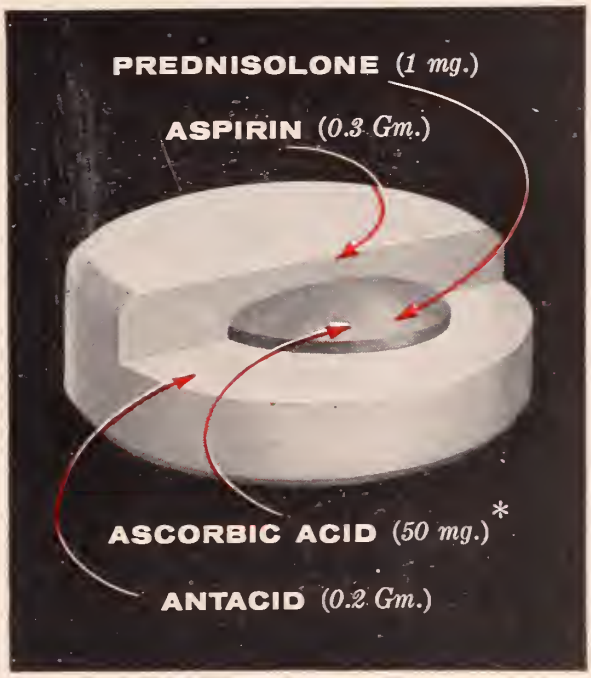
presents the principal crystalline alkaloid of rauwolfia...reduces the "psychic magnitude" of everyday stresses in patients with mild or labile hypertension.[3] Bottles of 100, 500, and 1000 scored tablets: 0.1-mg. white, 0.25-mg. yellow, and 1.0-mg. orange tablets.

1. Wilkins, R. W.: Ann. New York Acad. Sc. 59:36, 1954. 2. Meilman, E.: Circulation 13:596, 1956. 3. Wolferth, C. C.: Pennsylvania M. J. 59:327, 1956.

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Proper formula for treating "Rheumatism" patients

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With TEMPOGEN, many patients obtain adequate relief from immobilizing "rheumatic" pain with lower hormone dosages than are ordinarily required, because of the enhanced antirheumatic effect provided by the prednisolone-salicylate combination. In addition, the likelihood of the occurrence of gastric distress or adrenal ascorbic acid depletion is minimized.

INDICATIONS: Early rheumatoid arthritis, rheumatoid spondylitis, osteoarthritis, Still's disease, psoriatic arthritis, bursitis, synovitis, tenosynovitis, myositis, fibrositis, and neuritis.

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**present as 60 mg. sodium ascorbate*

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I haven't eaten a square meal in months!"

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Will help manage:

- The "Nibbler"
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Supplying the more effective 3 to 1 ratio of Dextro to Levo Amphetamine as suggested by Freed and Mizel. (1)

Providing a mild sedative to cantral nervousness and anxiety (2) often found in obese patients.

RABUDEX—G.R. capsules are released over a period of 8 to 10 hours with approximately one-third the total dose released in 15-20 minutes and the remaining two-thirds released gradually over the next 8 to 10 hours. As the effects may last as long as 12 hours, RABUDEX—G.R. should be given early in the day.

Each RABUDEX—G.R. Capsule contains 22.5 mg. dextra amphetamine — 7.5 mg. levo amphetamine plus Butaborbitol Sodium 45 mg. as provided by:

Dextro Amphetamine Sulfate ---------- 15 mg.
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Butabarbitol Sodium -- 45 mg.

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Available In Bottles Of 100 - 500 - 1,000 Capsules
Sample Supply On Request

REFERENCES

1. Freed, S. C., and Mizel, M.: Annals of Int. Med., June, 1952.
2. Dripps, R. D.: J.A.M.A. 139:148-150 (Jan. 15), 1949.

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OLEANDOMYCIN TETRACYCLINE

added certainty in treatment of respiratory infections

new multi-spectrum synergistically strengthened antibiotic formulation

SIGMAMYCIN adds certainty in antibiotic therapy, particularly for the 90% of patients treated at home or in the office where sensitivity testing may not be practical, and provides: a new maximum in therapeutic effectiveness, a new maximum in protection against resistance, a new maximum in safety and toleration.

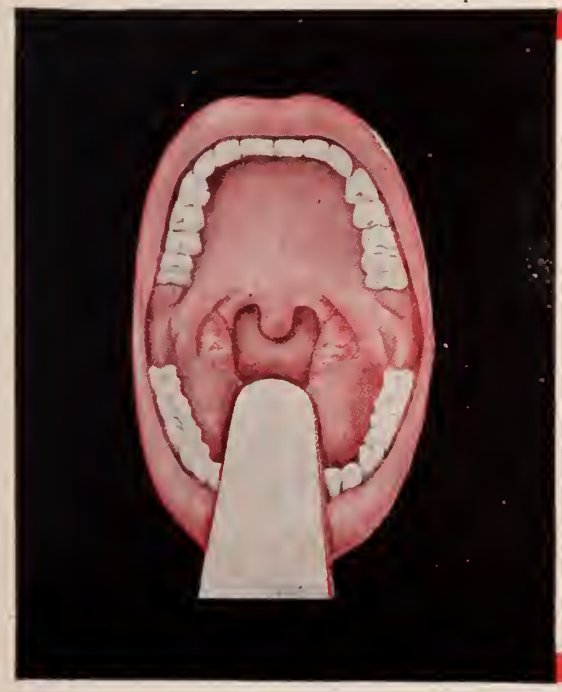
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. . . and for a new maximum in palatability

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World leader in antibiotic development and production



"...effective...in the treatment of a variety of infections seen regularly by the practicing clinician..." including pharyngitis, bronchitis and other respiratory infections

and "... often useful in the treatment of infections due to staphylococci resistant to one or several of the regularly used antibiotics"

"side effects . . . [are] notable by their absence"[1]

1. Carter, C. H., and Maley, M. C.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 51.



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PHARMACEUTICALS AND BIOLOGICALS

FOR THE MEDICAL PROFESSION

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Ortho Pharmaceutical Corporation

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Delivers a measured dose of true nebular vapor...Dose is always the same regardless of strength of fingers or amount of medication in bottle.

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Medihaler Oral Adapter is made of unbreakable plastic ...no moving parts...and 200 applications in each 10 cc. bottle.



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Riker brand of epinephrine U.S.P. 0.5% solution in inert, nontoxic aerosol vehicle. Each ejection delivers 0.125 mg. epinephrine. In 10 cc. vial with metered-dose valve.

Indicated in acute or recurring bronchospasm. Replaces injected epinephrine in many emergency situations.

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Riker brand of isoproterenol HCl 0.25% solution in inert, nontoxic aerosol vehicle. Each ejection delivers 0.06 mg. isoproterenol. In 10 cc. vial with metered-dose valve. • Indicated in acute or recurring bronchospasm.

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is also available in Medihaler-Nitro™ (octyl nitrite) for the rapid relief of angina pectoris...and Medihaler-Phen™ (phenylephrine-hydrocortisone-neomycin) for lasting, effective relief of nasal congestion.

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Because Rubraton tastes so good, most children actually look forward to taking it. What better way could there be for providing these essential nutrients?

Rubraton is indicated for combatting many common anemias and for correcting mild B complex deficiency states. It may also prove useful for promoting growth and stimulating appetite in poorly nourished children. (Not intended for treatment of pernicious anemia.)

Dosage: 1 or 2 teaspoonfuls t.i.d.

Supply: Bottles of 8 ounces and 1 pint.

1 teaspoonful (5 cc.) supplies:

Elemental Iron (as ferric ammonium citrate and colloidal iron)	38 mg.
Vitamin B_{12} activity concentrate	4 mcg.
Thiamine mononitrate	1.0 mg.
Riboflavin	1.0 mg.
Niacinamide	5 mg.
Pantothenic acid (Panthenol)	1.5 mg.
Pyridoxine hydrochloride	0.5 mg.

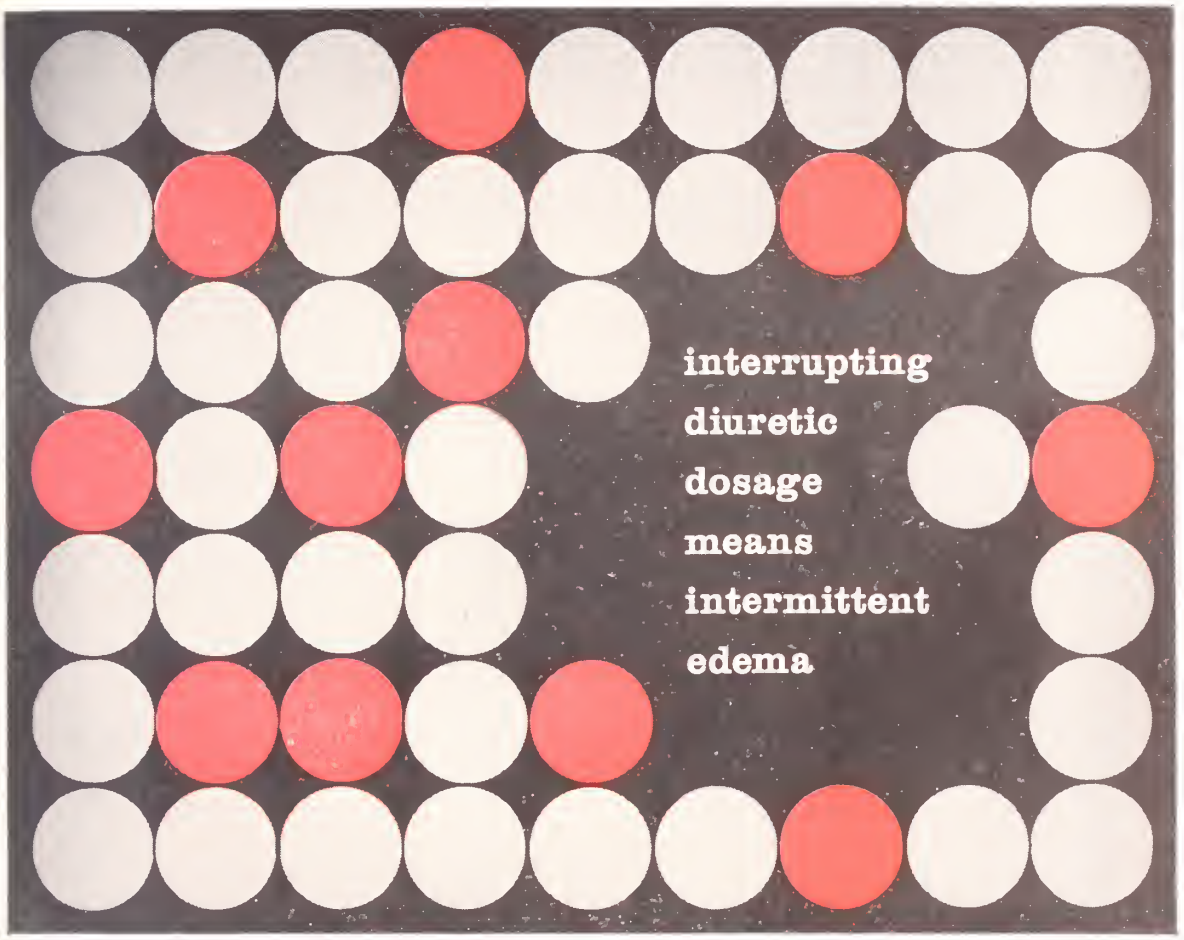
Alcohol content: 12 per cent

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SQUIBB IRON, B COMPLEX AND B_{12} VITAMINS ELIXIR

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Diuretics needing "rest periods," whether enforced by dosage restriction to once daily, or by omission to alternate days, inevitably fail to achieve sustained control of edema.

The organomercurials never require interruption of dosage to prevent refractoriness and can maintain patients continuously in the edema-free state.

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a standard for initial control of severe failure

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BRAND OF MERALLURIDE INJECTION

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NURSING HOME



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MEN and WOMEN

AGED

CHRONICALLY ILL

POST OPERATIVE

CASES

LICENSED BY THE STATE OF NEW JERSEY

SPACIOUS GROUNDS

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CONVENIENTLY LOCATED

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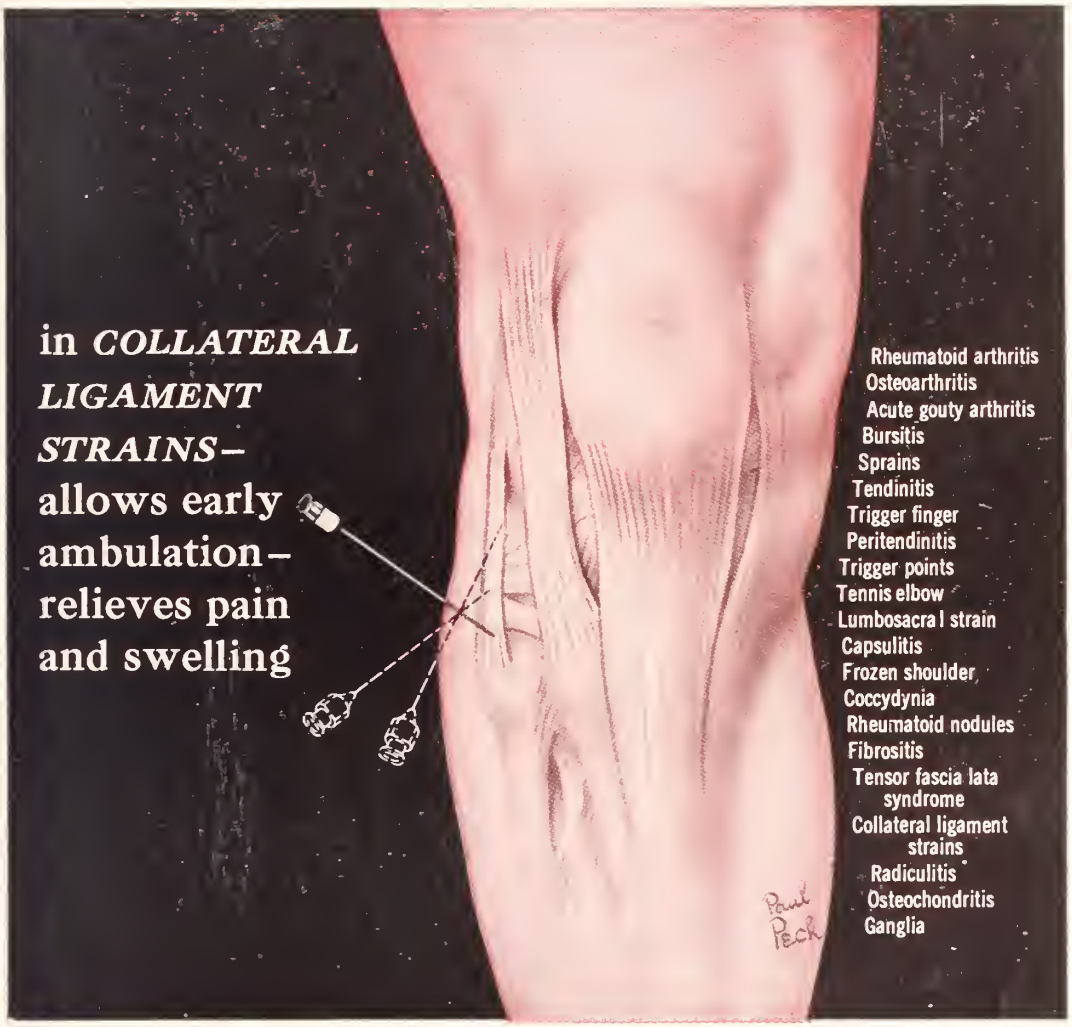
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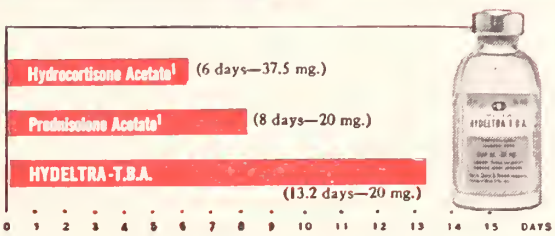
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for relief that lasts—longer



Duration of relief exceeds that provided by any other steroid ester



Dosage: the usual intra-articular, intra-bursal or soft tissue dose ranges from 20 to 30 mg. depending on location and extent of pathology.

Supplied. Suspension 'HYDELTRA'-T.B.A.—20 mg./cc. of prednisolone *tertiary*-butylacetate, in 5-cc. vials.

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DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.

1. Hollander, J. L., *Paper read at conference in New York City, May 31 and June 1, 1955*

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While discussing purulent cellulitis and sepsis due to staphylococci, Eastman, et al., mentioned erythromycin as a *drug of first choice in treating these conditions.*[2]

Meanwhile, Solomon and Johnston stated, *"in the staphylococcic and streptococcic infections, other than pneumonias, without exception the results of treatment with erythromycin were excellent."*[3]



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You, too, can have these same good results in your everyday practice—plus the assurance of prescribing a drug proved to be exceptionally well-tolerated in almost five years' use. *Filmtab* ERYTHROCIN Stearate (100 and 250 mg.), in bottles of 25 and 100.

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1. Herrell, W. E., Erythromycin, Antibiotics Monographs, No. 1, p. 34, New York, Medical Encyclopedia Inc., 1955. **2.** Eastman, G., Cook, E. and Bunn, P., N. Y. State J. Med., 56:241, 1956. **3.** Solomon, S. and Johnston, B., Amer. J. Med. Sc., 230:660, 1955.

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mtab—Film-sealed tablets, Abbott; pat. applied for.

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overwhelmingly favored by physicians in rheumatoid arthritis and bronchial asthma

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Because anemia complicates so many clinical conditions, 'TRINSICON' serves a vital function in your total therapy. It provides therapeutic quantities of all known hematinic factors. Just 2 pulvules daily provide a standard response in the average uncomplicated case of pernicious anemia and related megaloblastic types. 'Trinsicon' also offers at least an average dose of iron for hypochromic anemias, including nutritional deficiency types. Available in bottles of 60 and 500 at pharmacies everywhere.

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THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

The Conventional Doctor

Each year in this country, there are 250 medical conventions—at state, specialty or national level. This does not include annual meetings of county societies. About 50,000 *different* physicians attend these 250 sessions. Many doctors, of course, go to two or more conventions a year. If these assemblies were evenly spaced, it would mean five brand new conventions every single week throughout the year.

Getting to a convention is always something of a chore. Almost every state in the union* is larger than New Jersey, and therefore it is easier for New Jersey doctors to converge on a convention city for a state meeting than for practitioners in any other state in the country.* So we New Jersey physicians have less reason for not going than other doctors have. However, inconvenient or not, 50 thousand different M.D.s do manage to get to these annual meetings.

Why? What is the magnet that pulls so many busy practitioners from their offices, sends them rolling over crowded highways, soaring in the clouds, or riding on trains? No doctor makes money by going to a convention. Even with the allowed tax deduction, he is still out-of-pocket.

The nominal reasons are obvious. You learn something about medical practice at every convention. You visit a commercial exhibit and see a useful new gadget displayed or hear about a potent new drug. You hear a lot of papers. To some doctors every paper is a gem, a tiny graduate course all by itself. To some doctors, the average paper is a bore, a repetition of what he knows anyway, or a dreary recitation of unenchanting information. But even if this cynical doctor finds value in only

*Except our three fellow-miniatures Connecticut, Rhode Island and Delaware.

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Under the direction of the Committee on Publication
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Each paying member of the State Society is entitled to receive a copy of The Journal every month
Whole Number of Issues 632

Vol. 54, No. 4 April, 1957 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

10 per cent of the papers, he returns from the convention that much ahead of the game. And you see something useful — or maybe something exciting—at the scientific exhibits. Then too, you participate in the parliament of your profession. Whether as a voting delegate or as a voteless but vociferous member of the cheering squad (or heckling squad); whether as a committeeman or a back-seat driver, you are in there helping make or shape decisions about your own practice.

Those are the nominal reasons. But there are less rational factors. You meet old friends —colleagues you see only at this annual occasion. You participate in group activities with the brethren under conditions that do not always require Sunday manners. You get a chance to rub shoulders with some of the great men in American medicine. And you meet pleasant new friends who might be more interesting than the distinguished names.

You get away from the remorseless round of phone calls, sore throats, home visits, worried mothers, illegible prescriptions, third-class-mail, solicitors for worthy causes and incomplete insurance forms. If it's rest you want, it is rest you can get. If it's a change you need, that too can be provided. Remarkably enough, you can get what you want at or from a convention: excitement, information, rest, teaching, companionship, quiet, good food, change, debate, or relaxation. Here you can re-charge your storage batteries. You can breeze along in high gear, or coast in neutral. It's yours. All for the asking.

The Elegant Prescription

Our professional sires were much concerned about the taste and smell of the medication they prescribed. This made for "elegance" in the prescription. Nineteenth century medical students were drilled in the concoction of elixirs, syrups, and fluid extracts that had pleasant (or potent) smells and tastes.

With the increasing popularity of solid medications, and the decline of the tailor-made prescription, there is less emphasis on the flavor and odor of medication. And in a way, this is too bad. Every one prefers a pleasant tasting, pleasant smelling, (and for that matter pleasant looking) medication. An ill person is, as a rule, exquisitely sensitive to these things.

There is, furthermore, something special about the taste-smell sense. We bracket them here, for as Brillat Savarin (who ought to know) said "Smell and taste form but one sensation, with the mouth as the kitchen and the nose as the chimney." Sight and sound are physical sensations. Solid waves reach the retina or ear drum. Sight and sound are mechanically measurable with refractive technics and audiometers. But the smell-taste sense is chemical. It is wafted to us through the air, and no one has yet developed an objective, numerically calibrated, gustatometer or olfactometer.

They are—or it is—a primitive sensation, dependent for its evocative powers on factors far more subtle than those which work with sound or sight. The latter two senses now convey ideas with words, spoken or printed. But smell and taste must work without words, must work instead with moods, memories, sentiments and emotions. Odors are distinctive, and if undescribable are also inimitable. If sight and sound are the weapons of reason, smell and taste are the instruments of emotion.

In sickness we seek to help the bodies of patients. We also want to elevate their moods, to solace their emotions, to ease their minds and even attend to their souls. And in these areas, smell and taste are more potent than other sensations.

The chemists in America's wonderful pharmaceutical industry have been alive to this, and in distributing liquid medications, they *do* strive for elegance in taste and smell. But it is not good that we doctors have abdicated this function entirely to the manufacturer. It would hurt none of us to know how to disguise a bitter flavor with a palatable one, how to brew pleasant-smelling medicaments. It is always good taste to recognize good taste.

The 191st Annual Meeting
OF
The Medical Society of New Jersey

HADDON HALL, ATLANTIC CITY
April 27, 28, 29, 30, and May 1, 1957

Daily Schedule

Saturday, April 27, 1957

9:30 a.m.—Board of Trustees
Bakewell Room, 1st floor

12:00 noon—Registration Opens
Sun Porch, Lounge floor

2:30 p.m.—House of Delegates
Vernon Room, Lounge floor

8:00 p.m.—Open Discussion on Medical-Surgical Plan
Vernon Room, Lounge floor

8:30 p.m.—Nominating Committee
Bakewell Room, 1st floor

Sunday, April 28, 1957

11:00 a.m.—Reference Committees:
"A"
Room 1333, 13th floor
"B"
Room 1344, 13th floor
"C"
Mandarin Room, 13th floor
"D"
Room 1335, 13th floor
"E"
Room 1337, 13th floor
Constitution and By-Laws
Bakewell Room, 1st floor
Miscellaneous Business
Rowsley Room, 1st floor
Resolutions and Memorials
Room 1332, 13th floor

2:30 p.m.—Golden Merit Award Ceremony
Viking Room, 13th floor

4:00 p.m.—House of Delegates (election)
Vernon Room, Lounge floor

Monday, April 29, 1957

9:00 a.m.—Exhibits Open
Lounge floor

10:00 a.m.—House of Delegates
Vernon Room, Lounge floor

2:00 p.m.—General Session on Medicine
Viking Room, 13th floor

8:00 p.m.—General Session
Viking Room, 13th floor

Tuesday, April 30, 1957

9:00 a.m.—Board of Trustees
Bakewell Room, 1st floor

9:30 a.m.—Section on Allergy
Tower Room, 13th floor

10:00 a.m.—Sections:
Cardiovascular Diseases
West Room, 13th floor
Dermatology
Room 1344, 13th floor
Gastroenterology and Proctology
Rutland Room, 1st floor
General Practice
Vernon Room, Lounge floor
Neuropsychiatry
Viking Room, 13th floor
Otolaryngology
Mandarin Room, 13th floor

12:30 p.m.—Luncheons:
New Jersey Allergy Society
Rowsley Room, 1st floor
Section on Dermatology
Bakewell Room, 1st floor
Section on General Practice
Zodiac A, Chalfonte

2:00 p.m.—General Session on Surgery
Viking Room, 13th floor

2:30 p.m.—Special Session on Mental Health
West Room, 13th floor

7:00 p.m.—Dinner-Dance
Vernon Room, Lounge floor

Wednesday, May 1, 1957

9:30 a.m.—Sections:
Anesthesiology
Mandarin Room, 13th floor
Chest Diseases
Viking Room, 13th floor
Metabolism
Room 1344, 13th floor

10:00 a.m.—Sections:
Clinical Pathology
West Room, 13th floor
Ophthalmology
Rutland Room, 1st floor
Radiology
Tower Room, 13th floor
Rheumatism
Vernon Room, Lounge floor
Urology
Card Room, Lobby floor

12:30 p.m.—Luncheons:
Section on Chest Diseases and New Jersey Chapter, American College of Chest Physicians
Bakewell Room, 1st floor
Section on Metabolism and Medical Members, New Jersey Diabetes Association
Zodiac B, Chalfonte
Radiological Society of New Jersey
Blue Room, Chalfonte
2:00 p.m.—General Session on Obstetrics and Gynecology
Viking Room, 13th floor
3:00 p.m.—Exhibits Close
Lounge floor
4:00 p.m.—Registration Closes
Sun Porch, Lounge floor

Golden Merit Award Ceremony

Sunday Afternoon, April 28, 1957

Viking Room, 13th floor
2:30 p.m.

The first annual presentation of the Golden Merit Award of The Medical Society of New Jersey to those members who have been in practice fifty years.

General Session

Monday Evening, April 29, 1957

Viking Room, 13th floor
8:00 p.m.

Welcome
Lewis C. Fritts, M.D., President

Inaugural Address
Albert B. Kump, M.D., President-Elect

Forum on Medical-Legal Testimony
Presiding
Daniel F. Featherston, M.D., Chairman, Judicial Council
"The Medical Witness"
Film prepared under the direction of the Legal Department of the American Medical Association
Panel
A blue ribbon panel of speakers who will be able to give authoritative advice and counsel, will participate in this forum on practical points concerned with medical-legal testimony.
Question and Answer Period

Dinner-Dance

Tuesday Evening, April 30, 1957

Vernon Room, Lounge floor
7:00 p.m.

honoring
PRESIDENT AND MRS. LEWIS C. FRITTS

Toastmaster
C. Byron Blaisdell, M.D.
Welcome
Mrs. Bertram J. L. Sauerbrunn, President, Woman's Auxiliary
Introductions
Mrs. John C. Voss, President-Elect, Woman's Auxiliary
David B. Allman, M.D., President-Elect, American Medical Association
Albert B. Kump, M.D., President-Elect
Presentation of Fellow's Key
To: Lewis C. Fritts, M.D., President
By: Vincent P. Butler, M.D., Immediate Past-President
Entertainment and Dancing

Scientific Sessions

MONDAY AFTERNOON, APRIL 29, 1957

GENERAL SESSION ON MEDICINE

HERMAN H. TILLIS, M.D., Chairman, Newark
LOUIS A. PRINCIPATO, M.D., Secretary, Camden
Viking Room, 13th floor

2:00 p.m.

Lung Cancer

Oscar Auerbach, M.D., Chief of Laboratory Service, Veterans Administration Hospital, East Orange

Discussor: Emanuel Klosk, M.D., Newark

Fifty lung cancer autopsies at the VA Hospital, East Orange, N. J., were studied. The tracheobronchial trees were dissected from the lungs and cut into 208 comparable 4.0 mm. sections. Approximately 6000 slides were examined and the findings of basal cell hyperplasia, squamous metaplasia and carcinoma-*in-situ* recorded. The incidence of the latter was calculated.

The incidence and distribution of intramucosal carcinoma is discussed in relation to the pathogenesis of bronchogenic carcinoma. The data are then examined in relation to the clinical experience of early detection and surgical resection of primary lung cancer.

2:30 p.m.

Myeloid Metaplasia

Lester M. Goldman, M.D., Director of Laboratories, Newark Beth Israel Hospital, Newark

Discussor: Edward Fendrick, M.D., East Orange

An introduction attempts to clarify the meaning of myeloid metaplasia both by definition and further discussion of its relationship to myelofibrosis, osteosclerosis, polycythemia, chronic myelocytic leukemia and similar conditions. Several case reports are presented as examples of the varied states accompanied by myeloid metaplasia.

An overall concept is formulated suggesting the consideration of the reticulo-endothelial system as a single organ unit with extramedullary myelosis merely an expression of proliferative states which may be functional, benignly neoplastic, or malignant.

3:00 p.m.

The Management of Hypertension and Hypertensive Cardiovascular Disease

Dora Kinsey, M.D., Member of the Medical Associates of the Massachusetts Memorial Hospitals, Boston, Mass.

Discussor: Thomas J. White, M.D., Jersey City

The importance of careful appraisal of each hypertensive patient before instituting therapy is stressed. The report is primarily concerned with patients who have had a hypertensive and cardiovascular evaluation, grouped according to Smithwick's classification, and followed for from 1 to 15 years. Most had received medical treatment. Comparison of these medically treated patients is made with a matched surgically treated group. Indications for different types of therapy are discussed.

3:40 p.m.

Action and Uses of Ataractic Compounds — A Critique

W. Alan Wright, M.D., Montclair, Consultant, Hospital Center, Orange

Discussor: Harrison F. English, M.D., Trenton

Special problems arise in the clinical evaluation of ataractic compounds, because their primary effect is an alteration of subjective mood or psyche. In non-psychotic anxiety states, where newer ataraxics like hydroxyzine (Atarax®) find their greatest value, the absence of easily measurable objective changes requires that we evaluate such drugs directly in terms of their subjective effects on mood. Reliable measurements of such effects can be obtained with special clinical devices such as blind studies and the use of placebos. In the light of recent work using these technics, a number of ataraxics are evaluated and classified in terms of their clinical usefulness.

4:10 p.m.

Business Session

TUESDAY MORNING, APRIL 30, 1957

ALLERGY

HERBERT W. DIEFENDORF, M.D., Chairman, Summit
FRANCIS A. PFLUM, M.D., Secretary, Asbury Park
Tower Room, 13th floor

9:30 a.m.

The Allergic Survey—Fact and Fancy

Aaron Weiner, M.D., Chief of Allergy Clinic, Barnert Memorial Hospital, Paterson

A plea is made for a direct approach to the problem of specific allergic diagnosis. Every diagnostic tool should be utilized in its proper place. The history and environmental study are important means of arriving at a diagnosis. Too often, patients are subjected to the inconvenience and expense of extensive skin testing when the history, environmental study and physical examination would have disclosed the real source of the patient's illness and rendered skin testing unnecessary. Short case histories are given to illustrate the relative importance of each diagnostic modality.

10:00 a.m.

The Newer Drugs—Action and Reaction

William Greifinger, M.D., Attending in Medicine, St. James Hospital, Newark

Hundreds of new drugs are made available each year. Most of these were unknown a decade ago. These drugs are valuable but the physician must

understand their mechanism of action and be aware of their adverse side-effects. Only by such understanding can the doctor choose the proper drug for treatment with the least possible danger to the patient. A definition of types of reactions to drugs is offered followed by a discussion of three major categories of the new drugs: steroids, tranquilizers and antibiotics. In the exciting race to conquer disease, it is wise to take the time to analyze the weapons available.

10:30 a.m.

The Management of Wasp Venom Allergy

Mary Loveless, M.D., Associate Professor of Clinical Medicine, Cornell University Medical College, New York, N. Y.

The prophylactic management of extreme wasp-venom-hypersensitivity has been essentially limited in the past to avoidance of the insect. It is now possible to protect the allergic patient with a simple, annual intracutaneous injection with venom which has been extirpated in the sac of live wasps. The contents of six such sacs constitutes the course, which can be completed during a single visit of several hours, or more gradually during multiple visits. No untoward responses have been encountered in recent years with this method. Protection has been demonstrated against one, two and sometimes three stings in the field.

Wasp venom is urticariogenic for normal individuals. It has been used to determine the ranges of susceptibility in the skin and conjunctivae of 34 normal individuals. Decidedly more venom is required to elicit their responses than in the allergic group. Their responses to a planned wasp-sting were also observed.

11:00 a.m.

Program for the Rehabilitation of the Asthmatic Child

H. Emerson Burkhardt, M.D., Chief of Allergy Clinic, Atlantic City Hospital, Atlantic City

Too frequently the asthmatic child ends as a respiratory cripple. Time is not the essence; it runs out. The time to do something is now. The day is past when we can say: "your child will grow out of it." Offer your patient now a constructive educational positive approach to useful life through rehabilitation—even competitive sports.

Physical incapacities of the allergic asthmatic should be reevaluated so that he no longer feels it necessary to compete with stronger individuals but with those of similar levels. His inner tensions will then relax and the attacks lessen, even disappear. Thus can therapeutic results be evident.

11:30 a.m.

Business Meeting

12:30 p.m.

Luncheon—New Jersey Allergy Society
Rowsley Room, 1st floor
Reservations: Francis A. Pflum, M.D., Asbury Park

CARDIOVASCULAR DISEASES

Frank J. Brown, M.D., Chairman, Point Pleasant
Peter H. Marvel, M.D., Secretary, Northfield

West Room, 13th floor

10:00 a.m.

Special Features and Complications of Myocardial Infarction

Mortimer L. Schwartz, M.D., Irvington, Attending in Medicine, Medical Center, Jersey City

Discussor: Louis F. Albright, M.D., Asbury Park

Diagnosis of some cases of impending or frank myocardial infarction requires awareness of atypical symptoms ranging from dyspnea to shoulder-hand syndrome. Acute surgical abdominal conditions may mimic, be coincident with, or precipitate myocardial infarction.

Prevention and prompt recognition of complications including arrhythmias and heart failure can usually be accomplished by auscultation. Gallop rhythms should be searched for daily. Long-term anticoagulant therapy is indicated in ventricular aneurysm and selected cases of repeated infarction.

10:30 a.m.

Present Status of Clinical Ballistocardiography

Sidney R. Arbeit, M.D., Attending in Medicine, Medical Center, Jersey City

Discussor: Frank J. Brown, M.D., Point Pleasant

In limited but specifically defined areas the ballistocardiograph is now ready to be applied to the clinical practice of medicine. The diagnosis of angina pectoris may be confirmed, the presence of carditis in acute rheumatic fever may be indicated and the functional myocardial recovery after an acute infarction may be closely followed by ballistocardiograms. Current experimental work (such as the studies on the effects of digitalis) suggest further clinical applications for the ballistocardiograph in the near future.

The limitations of the method are stressed, especially in studies involving older subjects.

11:00 a.m.

Surgical Treatment for Intracardiac Defects

Henry T. Bahnson, M.D., Associate Professor of Surgery, Johns Hopkins University School of Medicine, Baltimore, Md.

Discussor: Anthony D. Crecca, M.D., Newark

Two technics: (1) hypothermia with inflow occlusion and (2) cardiopulmonary bypass with extracorporeal circulation, are available to allow work under direct vision upon intracardiac lesions. Hypothermia is used for treatment of auricular septal defects and pulmonary or aortic valvular lesions in which only a brief period of open cardiotomy is required. For more difficult lesions, such as a ventricular septal defect, more time is required and an extracorporeal circulation is used. Experience in the use of these technics is described.

11:40 a.m.

Business Meeting

DERMATOLOGY

HERMAN KLINE, M.D., Chairman, Atlantic City
FRANCIS J. MCCAULEY, M.D., Secretary, Newark

Room 1344, 13th floor

10:00 a.m.

Alopecia Areata and Other Common Scalp Problems
Harry C. Goldberg, M.D., Chief, Division of Dermatology, Muhlenberg Hospital, Plainfield

Colored slides will illustrate the more common scalp problems. Special attention will be devoted to alopecia areata. Long-term systemic administration of adrenocorticotrophic hormones and cortisone drugs bring about the regrowth of hair in alopecia areata. This therapy is unwarranted for a cosmetic defect, although in many patients this physical change produces disturbing emotional problems. Failure to produce hair regrowth in alopecia areata by the local application of the steroid drugs in ointment bases is described. Poor results follow iontophoresis of steroid drugs in areas of alopecia areata. Excellent results are obtained by the injection of hydrocortisone suspension into the affected areas. This is now the best effective treatment for alopecia areata. The technic, the results, the combination of the hydrocortisone suspension with hyaluronidase to make the injections practical and acceptable for the patient is described.

Also discussed is therapy of dandruff, seborrhea, psoriasis, dermatitis from hair tints, keratosis, malignancies and birth-marks. Particular attention is devoted to ringworm of the scalp.

10:20 a.m.

Verruca Vulgaris—A Method of Treatment
Herman Kline, M.D., Chief of Dermatological Clinic, Atlantic City Hospital, Atlantic City

A simple method of treating a selected group of warts is discussed, using the local application of tincture thuja. In a series of 76 cases, there was a "cure" rate of 81 per cent, with no recurrences or scar formation. Review of other methods and their purported successes or failures is used as a comparative test for the value of the thuja method of treatment.

10:40 a.m.

Rehabilitation of the Patient by Corrective Surgical Planing (Dermabrasion)
Seymour L. Hanfling, M.D., Dermatologist, East Orange General Hospital, East Orange

Corrective surgical planing, as perfected by Kurtin, has given us a remedy for acne and other facial defects. The indications are listed.

Although the patient is apprehensive before the first planing, those requiring a second or third are eager to have them done. This is because of the absence of pain during and after the procedure and the satisfactory results. The post-operative course is given from the patient's point of view. Cases are presented which show the changes in the patient's attitude after planing. In general, at least 50 per cent improvement can be expected with each planing. Although planing erases the skin scars, the long standing psychic scars cannot be so readily removed.

11:10 a.m.

Business Meeting

11:25 a.m.

Geriatric Dermatology
Leslie Nicholas, M.D., Associate Professor of Dermatology, Hahnemann Medical College, Philadelphia, Pa.

The principal anatomic and physiologic characteristics of the aging of the skin are reviewed. A correlation between these changes and the incidence of certain diseases is offered. Attention is called to those dermatoses which are frequently encountered in senile skin. This discussion includes allergic dermatoses, fungal diseases, vascular insufficiencies, nutritional deficiencies, and psychosomatic problems in addition to the cutaneous stigmata of aging and neoplastic degeneration.

12:30 p.m.

Luncheon—Section on Dermatology
Bakewell Room, 1st floor
Reservations: Herman Kline, M.D., Atlantic City

GASTROENTEROLOGY AND PROCTOLOGY

ABRAHAM L. REICH, M.D., Chairman, Newark
LEONARD TROAST, M.D., Secretary, Jersey City

Rutland Room, 1st floor

10:00 a.m.

Medical Aspects of Polyps in the Gastrointestinal Tract
Herbert B. Silberner, M.D., Adjunct in Medicine, Newark Beth Israel Hospital, Newark

Polyps occur anywhere in the gastrointestinal tract. They may cause bleeding or pain, but more often they produce no symptoms. They are important because of their tendency to malignant degeneration. There is a high incidence of multiple polyp formation and also of familial occurrence. Management will depend on the malignant potential, the location, the number, and the family history. Polyps should be looked for in routine physical examination, in gastrointestinal bleeding of obscure origin, and in vague abdominal pain.

10:20 a.m.

Roentgen Diagnosis of Polyps in the Colon
Leonard Troast, M.D., Attending in Gastroenterology, Medical Center, Jersey City

Despite advances in technic, the demonstration and diagnosis of polyps of the colon by roentgen methods alone is a difficult and trying procedure. A method of examination (illustrated by slides) will be presented. This includes preparation of the patient, fluoroscopy, spot films and carefully done post-evacuation and air contrast studies. Artifacts

and limitations of the technic are discussed. Emphasis is given to the necessity for correlation of the roentgen findings with the clinical and sigmoidoscopic picture.

10:40 a.m.

Polyposis of the Colon—Surgical Aspects and Experiences with Colonoscopy

Michael R. Deddish, M.D., Attending Surgeon, Rectal and Colon Service, Memorial Center for Cancer and Allied Diseases, New York, N. Y.

Adenomas and cancers of the colonic mucosa tend to be multiple and to co-exist. There is mounting evidence that the mucosal adenoma is the precursor lesion in a highly significant proportion of colonic cancers. Meticulous barium enema roentgen studies by air contrast and high voltage technics will demonstrate many of these tumors. Experience with endoscopic examination of the entire colonic mucosa reveals that only a 50 per cent pickup is obtained. The conservative treatment of early polyposis of the colon is the more reasonable approach to the treatment of this disease.

11:00 a.m.

Discussion:

Isaac Gelber, M.D., Elizabeth

General Discussion

11:30 a.m.

Business Meeting

GENERAL PRACTICE

Charles H. Calvin, M.D., Chairman, Perth Amboy
Malcolm M. Dunham, M.D., Secretary, Woodbridge

Vernon Room, Lounge floor

10:00 a.m.

Hypothyroidism—Diagnostic Implications

Irvin Sussman, M.D., Bridgeton, Chief of Medicine, Salem County Memorial Hospital, Salem

Hypothyroidism is a well recognized clinical entity in its typical form. Yet, the diagnosis may be overlooked if the clinician is not aware of the variability of symptoms with which this disease may be first presented to the physician. Several cases are cited of well advanced hypothyroidism in which the patients at first seemed more likely candidates for other diagnoses. Special emphasis is placed on the protean manifestations of the initial presenting syndromes.

10:30 a.m.

Preferred Management of Breast Lesions

William O. Wuester, M.D., Director, James S. Green Memorial Tumor Clinic, The Elizabeth General Hospital and Dispensary, Elizabeth

The more common breast lesions are illustrated. Methods of differential diagnosis are presented. Technics of management are reviewed and compared.

11:00 a.m.

Business Meeting

11:15 a.m.

Management of Chronic Chest Disease

Coleman B. Rabin, M.D., Attending Physician for Chest Diseases, Mount Sinai Hospital, New York, N. Y.

The management of chronic chest disease has undergone radical changes since the introduction of the versatile antibiotics and the steroids and since the development of technics for intrabronchial medication. The advances in thoracic surgery have made feasible the cure of the more localized types of disease with a low mortality. More diffuse diseases not amenable to surgical treatment have been modified by medical measures so that a more prolonged and comfortable life can be expected in patients who are not entirely curable.

The principles of the management of chronic bronchopulmonary disease are here presented. Illustrations show the individual diseases, in terms of both medical treatment and indications for surgery.

12:30 p.m.

Luncheon—Section on General Practice

Zodiac A, Chalfonte

Reservations: Charles H. Calvin, M.D., Perth Amboy

NEUROPSYCHIATRY

Harry H. Brunt, Jr., M.D., Chairman, Hammonton
Charles Englander, M.D., Secretary, Newark

Viking Room, 13th floor

10:00 a.m.

New Principles in Management of Mental Illness

V. Terrell Davis, M.D., Director, Division of Mental Health and Hospitals, New Jersey State Department of Institutions and Agencies, Trenton

Much of the symptomatology of the mentally ill is the product of socio-environmental treatment rather than a result of the basic nature of the illness. Recognition of this fact has led to the development of new principles in the management of the mentally ill. Adequate preparation of the patient for hospitalization, changing emphasis in psychiatric nursing, psychiatric units in general hospitals, day-care hospitals, family care programs, and facilities for children and the aging will be discussed.

10:30 a.m.

The Psychiatric Day Hospital and Its Relation to the General Practitioner

Joseph M. Tobin, M.D., Clinical Director, New Jersey State Hospital, Trenton

This paper will discuss the psychiatric "Day Hospital" as a community service designed to meet the needs of a selective group of patients, with whom the general practitioner deals frequently.

This review is based on an analysis of the results of a two-year study of the Day Unit of the New Jersey State Hospital at Trenton. The outline includes a history of the development of day unit care, the organization and function of the unit, treatment program, dynamic description of interpersonal relationships, milieu concept of therapy, selection of patients, evaluation of results and the role of the day unit in a comprehensive plan for community mental health.

11:00 a.m.

Psychiatric Researches in Perception

James H. Ewing, M.D., Assistant Professor of Psychiatry, University of Pennsylvania School of Medicine, Philadelphia, Pa.

Co-Authors: Karl Rickels, M.D., Assistant Instructor in Psychiatry; Jeanne L. Werntz, Ph.D., Instructor in Psychology in Psychiatry; and Johannes Lakke, M.D., Fellow in Psychiatry; University of Pennsylvania School of Medicine, Philadelphia, Pa.

Stress, whether due to factors within the individual or to external environmental factors induces alterations in perception. These changes range from failure to perceive cues, (as in anxiety or fear in normal people) to gross misperceptions, as in the psychoses. Perceptual functions can be altered experimentally by changing the organism, as for example with drugs, or by manipulation of the inanimate or animate environment. A variety of researches in this area of psychiatric investigation will be discussed with special reference to work now in progress at the University of Pennsylvania.

11:30 a.m.

Business Meeting

OTOLARYNGOLOGY

Warren E. Crane, M.D., Chairman, Trenton
William Rubin, M.D., Secretary, New Brunswick
Mandarin Room, 13th floor

10:00 a.m.

Present Status of Tonsil and Adenoid Surgery

Joseph R. Burns, M.D., Attending in Otolaryngology, The Mercer Hospital, Trenton

General Discussion

10:30 a.m.

Management of Recurrent Mixed Tumors of the Major Salivary Glands

William F. Keim, M.D., Attending in Otolaryngology, Hospital of St. Barnabas, Newark

General Discussion

Records will be presented of nine cases of recurrent mixed tumor involving the major salivary glands. Especial attention will be paid to the preservation of the function of the facial nerve and to the procedure best designed to reduce the possibility of further recurrence.

11:00 a.m.

A Simplified Procedure for Rhinoplasties

John C. Walker, Jr., M.D., Plastic Surgery Staff, Hospital of St. Barnabas, Newark

General Discussion

A method for the correction of nasal deformities resulting in a reduction in size and shape of the nose will be demonstrated by a colored movie film. Several of the most common deformities encountered in the plastic surgical field for surgery of the nose will be shown with the aid of colored slides. Clinical suggestions of practical value will be brought out in the discussion.

11:30 a.m.

Business Meeting

TUESDAY AFTERNOON, APRIL 30, 1957

GENERAL SESSION ON SURGERY

G. Ruffin Stamps, M.D., Chairman, Atlantic City
John L. Varriano, M.D. Secretary, Jersey City
Viking Room, 13th floor

2:00 p.m.

Repair of Common Duct Injuries

Lee Gillette, M.D., Attending Surgeon, Gastroenterological Clinic, and Assistant Attending Surgeon, Roosevelt Hospital, New York, N. Y.

Experiences with the repair of common duct injuries by choledocho-duodenostomy are presented. Its advantages and disadvantages (compared to direct repair or Roux 4 procedures) are discussed. Three interesting patients with this problem are presented. The author was associated with the late Dr. R. Franklin Carter in operating on a large series of these cases.

2:25 p.m.

Some Things to Remember in Treating the Injured

James H. Spencer, M.D., Attending in Surgery, Newton Memorial Hospital, Newton

In spite of a growing interest in new technics and new areas of surgery, the treatment of the injured still deserves a high priority in surgical thought and teaching. The increasing number of severe accidents resulting from modern high speed living continues to make the surgery of trauma one of the most challenging and rewarding fields in which the well trained surgeon can work.

In this paper, it is proposed to repeat some old truths and take a fresh look at this subject.

2:45 p.m.

Adrenal Denervation for Hypertension

Sherman A. Eger, M.D., Clinical Professor of Surgery, The Jefferson Medical College, Philadelphia, Pa.

This presentation reveals the latest developments in the improved technic of adrenal denervation

originated by the author. (This was awarded first prize as a scientific exhibit in 1955 by this Society.) Since then further improvements in technic have been made and more cases added.

Included are clinical data of 25 hypertensive patients who have been treated by this method during the past 6 years with improvement in 80 per cent; and a film demonstrating the operative procedure in detail and showing how the many hair-like adrenal nerves are isolated, severed and prevented from regenerating into the adrenal.

3:10 p.m.

Business Meeting

3:30 p.m.

The Community Blood Vessel Bank and Problems in Arterial Grafting

Norman Rosenberg, M.D., Highland Park, Chief of Vascular Surgical Sections, Middlesex General Hospital and St. Peter's General Hospital, New Brunswick

An artery bank has been in operation in Middlesex County for the past two years, employing ethylene oxide for sterilization of the vessels with storage in the "freeze-dried" state.

Experiences in the operation of such a bank, as well as problems in procurement of arteries are discussed.

The applications of arterial homografts and other prostheses in clinical case material are illustrated.

SPECIAL SESSION ON MENTAL HEALTH

West Room, 13th floor
2:30 p.m.

Presiding: Robert S. Garber, M.D., Chairman, Special Committee on Mental Health

Talking With the Patient

Stewart G. Wolf, Jr., M.D., Professor of Medicine, University of Oklahoma School of Medicine, Oklahoma City, Okla.

Communication is the basis of any medical practice. How to set the stage for an informative interview, and how to recognize the less obvious, but important, psychologic factors in talking with patients will be discussed. Technics in psychotherapy for the general physician will be presented. The paper will conclude with a discussion of the question of when and how to refer patients to a psychiatrist.

ANESTHESIOLOGY

Lester W. Netz, M.D., Chairman, Hackensack
Bertha P. Rodger, M.D., Secretary, Ridgewood

Mandarin Room, 13th floor

9:30 a.m.

Safe Dental Office Anesthesia for Protracted Cases —An Urgently Needed Service of Anesthesiology

Charles H. Hall, Jr., M.D., Attending in Anesthesiology, Saint Joseph Hospital, Paterson

Co-Authors: Vincent Varallo, D.D.S., Edward T. Lawless, M.D., Francis Kelly, M.D., Robert Mulholland, M.D., and Peter Tucci, M.D.

Dentistry has mastered technics of regional anesthesia. General anesthesia in dentistry has been customarily reserved for the short cases. However, patients who require anesthesia for a relatively long period can be done safely under general anesthesia under certain conditions. In this paper, those conditions are discussed. Also reviewed is the kind of equipment needed. The skilled anesthesiologists can provide the equipment needed and it can be transported easily. Skillful anesthesiologists can provide safety for the patient.

The dentist is enabled to work in his own office with all the equipment he needs, in a familiar environment. Also, the patient is spared the additional hospital expense which is not provided for by most insurance policies.

9:50 a.m.

Rectal Methitural

Frank Pfaff, M.D., Attending in Anesthesiology, Holy Name Hospital, Teaneck

Co-Authors: Leo J. Fitzpatrick, M.D., D'Arcy Clarie, M.D., and Marcel A. Mersch, M.D., Department of Anesthesiology, Holy Name Hospital, Teaneck

This study was designed to explore the usefulness of methitural sodium as a rectal hypnotic in children. A 10 per cent solution was given rectally in the operating room. A 10 per cent solution of thiopental served as a control.

From the information obtained from the first series of cases, a high and low dose of each drug was given to construct a dose regression curve. The children were selected randomly in respect to the rectal drug. All children were to undergo a tonsillectomy. When the child was asleep, cyclopro-

pane was administered for intubation. The primary agent was nitrous oxide supplemented with cyclopropane or trichloroethylene. The recovery time was measured as the interval between extubation and the time the child responded to his name.

Information was thus gathered on the relative sleep time of methitural and thiopental given rectally. At the same time, information was obtained about the recovery time.

10:10 a.m.

An Evaluation of Cardiac Arrhythmias During Intubation

Gene L. D'Alessandro, M.D., Chief of Anesthesiology, Presbyterian Hospital, Newark
Co-Author: Rolf Vlatten, M.D., Department of Anesthesiology, Presbyterian Hospital, Newark

Electrocardiographic changes were studied in 100 patients who were subjected to a first induction and intubation with an intravenous barbiturate and a relaxant drug. Comparison was made of the changes between the intubations with and without topical anesthesia. The kinds of cardiac arrhythmias were listed. The effect of this technic on patients with preoperative signs of myocardial damage is shown. The value of oxygenation of the patient before intubation is discussed. While changes in the electrocardiographic recordings were of a transient nature, some of the patterns can potentially result in ventricular tachycardia and finally to ventricular fibrillation.

10:30 a.m.

The Use of Leritine—A New Narcotic for Surgical Anesthesia and Postoperative Analgesia

Irving M. Riffin, M.D., Attending in Anesthesiology, St. Vincent's Hospital, Montclair

In recent times, interest in *light* anesthesia or, better, *analgesia* has increased. Anileridine®, a new narcotic, has been used to potentiate the analgesic properties of nitrous oxide for major and minor surgery. The technic is presented. An evaluation of this drug for postoperative pain will also be reviewed. The narcotic has been tried on a small series of cases for obstetrical analgesia. Its effectiveness will be discussed.

10:50 a.m.

Recess

11:00 a.m.

Recent Developments in the Pharmacology of Muscle Relaxants and Their Clinical Implications

Francis F. Foldes, M.D., Department of Anesthesiology, Mercy Hospital, Pittsburgh, Pa.

Question and Answer Period

Recent experimental findings have shown that on prolonged administration of depolarizing relaxants (*e.g.* succinylcholine, decamethonium) the sensitivity of the endplate to depolarizing influences decreases. This change in the properties of the endplate may be manifested by a gradually decreasing sensitivity to depolarizing relaxants, a marked increase in the sensitivity to non-depolarizing relaxants (*e.g.* d-tubocurarine, gallamine) or even by a change in the type of block produced by depolarizing relaxants from a depolarization block to a non-depolarization block. The dangers inherent to the indiscriminate use of relaxants are discussed. The relationship between the changed sensitivity of the endplate and certain types of prolonged apneas encountered (with the use of depolarizing relaxants) is reviewed. The applicability of non-depolarizing relaxants in patients sensitized by prolonged use of depolarizing agents is considered.

11:45 a.m.

Business Meeting

CHEST DISEASES

WILBUR F. JEHL, M.D., Chairman, North Caldwell
ARTHUR BERNSTEIN, M.D., Secretary, Newark

Viking Room, 13th floor

9:30 a.m.

The Surgical Management of Multivalvular Heart Disease

Alfred R. Henderson, M.D., Asbury Park, Attending in Cardiovascular-Thoracic Surgery, Fitkin Memorial Hospital, Neptune

Multiple simultaneous valvulotomy has been performed upon 22 patients with acquired heart disease. These represent a segment of a series of 121 patients operated upon for rheumatic valvular heart disease.

Multi-valvular involvement can be feasibly operated as one procedure. The morbidity and mortality depends for the most part upon the physiologic reserve of the patient.

Particular emphasis is placed on early operation in cases where both aortic and mitral valves are involved. Patients with pure mitral stenosis may often be saved and maintained through numerous bouts of failure. But when aortic stenosis also exists (with its direct and profound reflections on the left ventricle) the onset of initial failure usually signifies impending death.

Early surgical intervention before frank failure occurs is mandatory. The role of left heart catheterization is discussed.

9:45 a.m.

Transient Pulmonary Infiltrates in Smokers

Irving L. Applebaum, M.D., Attending in Medicine, Newark Beth Israel Hospital, Newark
Co-Authors: M. Shoshkes, M.D., and B. Levine, M.D., Newark

Six cases with transient pulmonary infiltrates are presented. All known etiologic agents were eliminated. Except for a so-called "cigarette cough," all patients were asymptomatic and had a benign course. The one factor common to all cases was tobacco smoking. Cessation of or reduction in

smoking was followed by complete disappearance of the roentgen opacities. It must therefore be assumed that the tobacco smoking habit is the causative agent involved.

The most likely mechanism for this pulmonary lesion is an inflammatory obstruction of a peripheral bronchus with a resultant atelectasis in that segment.

10:00 a.m.

Clarification of the Present Status of Accepted Operative and Non-Operative Lesions of the Heart

Nicholas A. Antonius, M.D., Director, Department of Cardiology, St. Michael's Hospital, Newark

Co-Authors: Anthony D. Crecca, M.D., Newark, and Lucien G. Massarelli, M.D., West Englewood

The enthusiasm generated by the remarkable advances in the operative treatment of cardiovascular disease had led to confusion about the acceptability of candidates for operation. Another source of confusion is the availability of a reliable surgical procedure for a given cardiovascular lesion. We must clarify the indications for operation and the factors involved in achieving a good clinical result. It is imperative that operations be selected within the limits of good clinical risk and that the surgeon exercise proper self discipline in the selection of technics that fall within the scope of his experience and the limits of the facilities.

10.15 a.m.

The Active Management of Pulmonary Tuberculosis in Pregnancy

Irving J. Selikoff, M.D., Associate in Medicine, Barnert Memorial Hospital, Paterson

Co-Author: Henry L. Dorfmann, M.D., New York, N. Y.

The incidence of pulmonary tuberculosis in pregnancy varies with the diligence with which it is sought. In many large clinics, routine full-size x-rays uncover approximately 3.5 per cent. In the experience of the authors over 225 cases were found in 7500 consecutive ante-natal examinations of pregnant women. One-third had active disease, more than one-half had had no previous history.

Active disease presented no problem: it was treated, and it responded as well as similar disease without pregnancy. Inactive disease was treated prophylactically with chemotherapy. There were no reactivations. This appeared to solve the problem of the *difficulty of evaluation of activity.* Mistakes are expected in about 10 per cent in most series. With pregnancy, such mistakes would be serious. Chemotherapy caused *regression* in some "inactive" cases, indicating that the original evaluation was incorrect, but avoiding the consequences thereof. Prophylactic therapy served as a "therapeutic test" of activity.

10:30 a.m.

Errors in Interpretation of I 131 Tracers in Cardiac Patients

Wade N. Miller, M.D., Physician-in-Chief, Black-Stevenson Memorial Clinic, Presbyterian Hospital, Newark

In the course of conducting iodine^{131} tracer studies it has been found that patients with congestive heart failure may frequently concentrate iodine ^{131} in the thyroid gland in normal amounts but fail to show other normal indices of thyroid function. Uptake studies may not parallel other measurements of iodine metabolism such as iodine ^{131} protein-bound iodine, conversion ratios, saliva/plasma ratios, and saliva/protein-bound iodine ratios. The possible interpretations of these data will be discussed.

10:45 a.m.

Pectus Excavatum

Adrian M. Sabety, M.D., Associate in Thoracic Surgery, The Mountainside Hospital, Montclair

Pectus excavatum or funnel chest is a congenital developmental deformity of the sternum and costal cartilages. Surgical correction is indicated primarily for removal of cosmetic defect which may be a social handicap, and for correction of a skeletal deformity, which may cause cardiac or pulmonary complications. Most operations are based on the principles of Brown; that is maintaining sternal elevation. However, methods of dealing with the deformed cartileges and permanent fixation of the anterior bony chest wall differ. The method used in cases here reported requires no traction or added external support. This was a definite factor in the lack of mortality in the cases here reported. The younger the patient, the greater is the likelihood of obtaining a completely normal thoracic contour. Our patients ranged in age from 16 months to 20 years and the longest follow-up is five years. The cosmetic result correlates with the age of the patient.

11:00 a.m.

Cardiac Damage Occurring While at Work—Problems in Determination of Disability and Compensability

David Roth, M.D., Adjunct in Medicine, Barnert Memorial Hospital, Paterson

Compensation suits arising from cardiac disease, traumatic or degenerative, are not great in number but bulk large financially in our compensation courts. Rehabilitation and reemployment of cardiacs are also seriously hampered by the fear of increased compensation costs.

Cardiac damage due to physical trauma is briefly discussed. Recent advances in the patho-physiology of arteriosclerotic heart disease have made the criterion for compensability of "unusual stress" a dubious one. The dynamic balance between myo-

cardial oxygen demand and coronary supply is stressed and its relation to the effect of work on the heart.

Possible changes in the law are surveyed.

11:10 a.m.

Business Meeting

11:20 a.m.

Open Discussion on All Papers

12:30 p.m.

Luncheon—Section on Chest Diseases and New Jersey Chapter, American College of Chest Physicians

Bakewell Room, 1st floor

Reservations: Arthur Bernstein, M.D., Newark

CLINICAL PATHOLOGY

GEOGRE L. ERDMAN, M.D., Chairman, Summit
MURRAY W. SHULMAN, M.D., Secretary, Newark
West Room, 13th floor

10:00 a.m.

A Clinical Pathological Conference

Moderator: George L. Erdman, M.D., Chairman, Section on Clinical Pathology

Discussant: Alexander B. Gutman, M.D., Director, Department of Medicine, Mount Sinai Hospital, New York, N. Y.

Pathologist: Martin R. Rush, M.D., Director of Pathology, Monmouth Memorial Hospital, Long Branch

An instructive case is presented from the files of the New Jersey Pathologists. The discussant, who has not been given the postmortem findings, will discuss the differential diagnoses on the basis of clinical history, physical findings, and laboratory data. The pathologist will present the autopsy findings with the aid of appropriate illustrations. The case history will be available in mimeographed form at the meeting.

11:00 a.m.

Business Meeting

11:10 a.m.

Microdrepanocytic Disease

Donald E. Brown, M.D., Director of Laboratories, Hackensack Hospital, Hackensack

Co-Author: William B. Ober, M.D., Assistant Pathologist, Hackensack Hospital, Hackensack

Discussor: Jacob Churg, M.D., Paterson

A case of microdrepanocytic disease is reported and discussed. This appears clinically not unlike sickle cell anemia. Genetically, however, the patient is not homozygous for sickle hemoglobin, but has one gene for sickle hemoglobin and one gene for thalassemia. The diagnosis was suspected on the basis of a high normoblast count and an enlarged spleen. It was confirmed by studies on other members of the family. The relationship to pregnancy is considered.

11:30 a.m.

The Clinical Significance of Alterations in Serum Transaminases

Felix Wróblewski, M.D., Assistant Professor of Clinical Medicine, Cornell University Medical College, New York, N. Y.

Transaminase® is an enzyme concerned with the transfer of the alpha-amino group of one amino acid to the alpha-keto group of a keto acid resulting in the synthesis of another alpha-amino and another alpha-keto acid. The distribution of glutamic oxaloacetic Transaminase® and of glutamic pyruvic Transaminase® in hemogenates of human tissues and serum are different and specific. Both serum enzymes (SGO-T and SGP-T) may be measured chromatographically, spectrophotometrically and colorimetrically.

The measurement of SGP-T alterations has been found to be a useful tool in the diagnosis and study of acute infectious and toxic hepatic disease and acute extra-hepatic biliary obstruction, and is more sensitive than SGO-T in reflecting acute hepato-cellular injury. SGO-T alterations more sensitively reflect chronic hepatic disease and acute myocardial infarction.

METABOLISM

NORMAN L. MURRAY, M.D., Chairman, Summit
WILLIAM LEVISON, M.D., Secretary, Newark
Room 1344, 13th floor

9:30 a.m.

Hypoglycemic Agents

John G. Rogers, M.D., Riverton, Assistant in Internal Medicine, Burlington County Hospital, Mount Holly

The sulfonurea compounds are orally effective hypoglycemic agents. Their mode of action is most likely a direct stimulation of the pancreas. Clinically they work well in mild overweight adult diabetics, rarely in labile insulin-resistant patients, and, in general, do not work in young patients. These drugs are not substitutes for insulin and are ineffectual in ketosis and infections. Toxicity includes dermatitis, leukopenia, and thyroid depression. About one third of patients who respond initially to the compounds later escape. Since these drugs appear to be of benefit only as a matter of convenience, more study of their toxicity and long term effect on the diabetic state are necessary before they are recommended for the general diabetic population.

10:00 a.m.

The Liver in Diabetes

Carroll M. Leevy, M.D., Director of Clinical Investigation, Medical Center, Jersey City

The liver in diabetes differs from normal in that there is decreased utilization of acetyl co-enzyme A in the Kreb's cycle, a decrease in fatty acid and

protein synthesis, and an underutilization as well as overpopulation of glucose. Nutritional deficiency coupled with inherent metabolic defects is responsible for a high incidence of hepatic abnormalities in poorly controlled diabetes. Treatment of complicating liver disease consists of a balanced diet, vitamins, and insulin. Preliminary experience indicates arylsulfonureas may also be effective; however, their failure to restore normal intermediary metabolism makes insulin the drug of choice for management of the diabetic with liver disease.

10:30 a.m.

Use of Radioactive Iodine in the Diagnosis and Treatment of Thyroid Disease

Martin Perlmutter, M.D., Chief, Endocrinology Clinic, Maimonides Hospital, Brooklyn, N. Y.

A brief review of pituitary-thyroid interrelationships will be given. The data will then be applied to the diagnosis of thyroid disease using radioactive iodine. The effect of thyroid hormone ingestion upon iodine uptake in normal and hyperthyroid patients will be compared. The avidity of thyroid nodules for radioactive iodine will be presented as a guide to the use of either medical or surgical therapy. The medical and surgical treatment of Graves Disease will be discussed.

11:00 a.m.

Metabolism and Bone Disease (Except Hyperparathyroid Disease)

Isidore Snapper, M.D., New York, N. Y., Director, Department of Medicine and Medical Education, Beth-El Hospital, Brooklyn, N. Y.

11:30 a.m.

Business Meeting

12:30 p.m.

Luncheon—Section on Metabolism and Medical Members, New Jersey Diabetes Association
Zodiac B, Chalfonte
Reservations: William Levison, M.D., Newark

OPHTHALMOLOGY

John Scillieri, M.D., Chairman, Paterson
Samuel M. Diskan, M.D., Secretary, Atlantic City

Rutland Room, 1st floor

10:00 a.m.

Symposium on Severe Visual Disability — "Subnormal Vision"

Moderator: John Scillieri, M.D., Chairman, Section on Ophthalmology

This opens a discussion and summary of papers on subjects of value and importance in the ophthalmologist's office. The pitfalls of visual disability therapy will be discussed. Data will be given to indicate that we should not become lax in this field. Other reports will indicate the danger of becoming too enthusiastic.

Optical Principles and Pathological Considerations

Edwin F. Tait, M.D., Clinical Professor of Ophthalmology, Temple University School of Medicine, Philadelphia, Pa.

Visual disabilities not correctable with ordinary glasses are due to disease in the light transmitting tissues of the eye or in the structures making up the afferent visual nervous system. The type of pathologic change which causes the visual disability usually determines the character of the remedial appliance.

In many of these cases, optical aids, such as contact lenses, pinhole or stenopaic discs, telescopes, or simple magnifying lenses, may produce visual improvement. The optical principles involved in these devices are principally those which concern magnification and control of the aperture of the system.

Binocular Correction for the Low Vision Patient

Gerald Fonda, M.D., Short Hills, Assistant in Ophthalmology, Overlook Hospital, Summit

Binocular corrections with reading additions as strong as plus 10.00 diopters have been successfully prescribed for patients with low vision.

The rule of thumb for decentration states that each reading lens or bifocal segment is decentered in one millimeter for each diopter of reading addition. The rationale for this statement is offered by comparison with the precise methods of Lebensohn and Tait.

Clinical Application of Optical Aids in the Management of the Patient with Severe Visual Disability

Charles E. Jaeckle, M.D., East Orange, Assistant in Ophthalmology, Orange Memorial Hospital, Orange

The patient with severe visual disability presents a complex problem. Evaluation requires consideration of etiology, pathology, ophthalmologic, and general diagnosis, prognosis, occupational and sociologic factors and the possibility of remedial medical and surgical therapy as well as "optical" improvement in vision *per se*. All bear on the use of optical aids, which are incidental to the total medical care.

Factors in the selection and treatment of patients are discussed. The clinical procedure is described in prescribing optical aids and re-educating the partly-blind patient to make the optimum use of his remaining vision. Illustrative cases are reported with 3, 5, and 10 years follow-up.

Percentage Evaluation of Visual Disability

A. Russell Sherman, M.D., Attending Surgeon, Eye Department, Newark Eye and Ear Infirmary, Newark

It is frequently necessary for an ophthalmologist to certify that a person is "blind," or in the case of the partly-sighted, to state what per cent

of vision remains. Methods of making these determinations will be discussed, together with suggestions for modifications of our present system.

11:30 a.m.

Business Meeting

RADIOLOGY

VINCENT M. WHELAN, M.D., Chairman, Red Bank
JULES H. BROMBERG, M.D., Secretary, Newark

Tower Room, 13th floor

10:00 a.m.

Blood Volume Determination Using Iodinated Human Serum Albumin

Vincent M. Whelan, M.D., Red Bank, Director of Radiology, Monmouth Memorial Hospital, Long Branch

Radioactive "tagging" has made available easier and more accurate means of estimating blood volume. The routine quantitative blood examinations, such as the red cell count, hemoglobin, and hematocrit, are often misleading in clinical evaluation. The more helpful information of blood volume determination should find wider usefulness in the handling of medical and surgical problems in which the value of the oxygen carrying power and the plasma constituents are important factors in understanding the phase of the disease and the requirements of replacement therapy.

10:20 a.m.

Practical Telopelvimetry

Franklin L. Reed, Jr., M.D., Director of Radiology, Morristown Memorial Hospital, Morristown

This paper presents a technic for obtaining films of maternal pelvis at 72 inch distance with patient in standing position. The advantages of the method are discussed.

10:40 a.m.

The Feet as an Index of General Body Health

Ralph G. Rohner, M.D., New York, N. Y., Chief of Orthopedic Surgery, Veterans Administration Regional Office, Newark

Human feet seldom serve as an indication of general body health. This only because they are seldom visualized by the examining physician unless there is a complaint referable to the feet as an entity. This paper suggests that features in the feet such as anatomic conformation, texture of skin and nails, color, temperature, hygiene, abnormalities acquired and congenital, and radiographic studies, afford a clue as to the clinical status of the patient or even possibly a positive diagnosis as to the presence or absence of a disease.

11:10 a.m.

The Bioanalytical and Genetic Effects of Radiation

Walter H. Mendel, M.D., New York, N. Y., Chief of Radiology, Veterans Administration Regional Office, Newark

11:40 a.m.

Business Meeting

12:30 p.m.

Luncheon—Radiological Society of New Jersey
Blue Room, Chalfonte
Reservations: George G. Green, M.D., Asbury Park

RHEUMATISM

EVELYN Z. MERRICK, M.D., Chairman, Orange
WILLIAM D. KIMLER, M.D., Secretary, Haddon Hts.

Vernon Room, Lounge floor

10:00 a.m.

Home Care of the Arthritic Patient

Ronald W. Lamont-Havers, M.D., Associate Medical Director, Arthritis and Rheumatism Foundation, New York, N. Y.

Physicians are showing increasing interest in programs which utilize a variety of treatment facilities for their home-bound or nursing home patients with arthritis or other rheumatic diseases. Facilities include the services of a physiotherapist, occupational therapist, nurse, social worker, and home maker. The manner in which these services can be utilized by the physician and the results that can be expected are discussed.

10:20 a.m.

Osteoporosis

Edward E. Henderson, M.D., Researchist, Bloomfield

Osteoporosis is the most prevalent of all bone diseases in old age. The Albright concept (that is a defect of protein metabolism rather than primary calcium loss) has now been generally accepted. Almost all women past the menopause will show some osteoporosis and a very large proportion of men over 60 will show some thinning of the bone structure. The disease may be entirely nonsymptomatic or it may cause excruciating pain. Positive diagnosis can be made only by x-ray. Treatment is satisfactory. A generous protein diet, plus the administration of anabolic steroids will provide prompt relief from pain, although x-ray evidence of improvement in the bone structure may not be evident.

10:40 a.m.

Evaluation of Diagnostic Aids in the Rheumatic Patient

Moderator: Peter J. Warter, M.D., Chief of Rheumatology, Wm. McKinley Memorial Hospital, Trenton

Gout

John W. Gray, M.D., Consultant in Arthritis, Hospital of St. Barnabas, Newark

Soft Tissue Lesions

Irving L. Sperling, M.D., Attending in Arthritis, Hospital of St. Barnabas, Newark

Rheumatoid Arthritis

Clarence B. Whims, M.D., Chief of Medicine, Atlantic City Hospital, Atlantic City

Osteoarthritis

Walter R. Edwards, M.D., Associate in Medicine, Wm. McKinley Memorial Hospital, Trenton

Question and Answer Period

The rheumatic problem is very perplexing at times. Often the most astute observer and student of rheumatology is pressed to the limit of his ability to arrive at a correct diagnosis. A successful therapeutic program is predicated upon the proper diagnosis.

The many methods which aid in the diagnosis of the various rheumatic problems will be briefly presented.

Questions from the floor will be discussed by the panel.

11:30 a.m.

Business Meeting

12:30 p.m.

Luncheon—Section on Rheumatism
Rowsley Room, 1st floor
Reservations: Evelyn Z. Merrick, M.D., Orange

UROLOGY

Ralph S. Ferenchak, M.D., Chairman, Plainfield
Arthur T. Willetts, M.D., Secretary, Summit
Card Room, Lobby floor

10:00 a.m.

Cattell T-Tube in Urological Surgery

Reginald F. Seidel, M.D., Attending in Urology, Englewood Hospital, Englewood

Richard B. Cattell devised a new type of T-tube for surgery of the biliary tract. Several uses for this tube have been found in urologic surgery. This paper suggests the possible advantages of this tube and also the contra-indications in some cases.

Urologic cases are presented to illustrate the various surgical procedures in which this tube was used both for splinting and for drainage of the ureter and kidney.

10:25 a.m.

Transurethral Prostatic Resection with Special Reference to Patients Eighty Years of Age and Over

George W. Irmisch, M.D., Attending in Urology, Wm. McKinley Memorial Hospital, Trenton

Extremely old men with disease of the urinary tract are better risks for surgical procedures than is commonly appreciated. Severe illness and death can often be avoided or postponed by electing to do an operation rather than carry the patient along on temporizing measures which, in themselves, involve a high risk.

This paper deals with pre-operative examination and preparation for prostatic surgery, the proper selection of an operative procedure which is short in duration avoiding shock, and further describes the use of alert postoperative management to avoid complications.

10:50 a.m.

Nephro-Duodenal Fistula

Edward A. Brady, Jr., M.D., Senior Attending in Urology, St. Peter's General Hospital, and Middlesex General Hospital, New Brunswick

A case is presented of a 56-year old woman with a spontaneous nephro-duodenal fistula secondary to tuberculosis and renal calculus disease of the right kidney. This was treated successfully by nephrectomy. A review of the literature is presented with an additional nineteen cases being discussed. The etiology, treatment and results of these twenty cases are presented.

11:15 a.m.

Primary Closure of the Exstrophied Urinary Bladder

Ralph J. Veenema, M.D., Attending in Urology, Valley Hospital, Ridgewood

This paper describes the Sweetser technic of primary closure of the exstrophied urinary bladder and relates the experiences with this method as used on the Babies Hospital Service of the Squier Urologic Clinic at Columbia-Presbyterian Medical Center, New York. Other forms of management of bladder exstrophy are briefly reviewed. Advantages of maintaining complete separation of urinary drainage and feces are emphasized.

11:40 a.m.

Business Meeting

WEDNESDAY AFTERNOON, MAY 1, 1957

SPECIAL SESSSION ON
OBSTETRICS AND GYNECOLOGY

STANTON H. DAVIS, M.D., Chairman, Plainfield

FREDERICK J. FAUX, M.D., Secretary, Woodbury

Viking Room, 13th floor

2:25 p.m.

Prematurity as an Obstetrical Problem

B. Frank Lovett, M.D., Associate in Obstetrics, Cooper Hospital, Camden

Discussor: Robert A. Cosgrove, M.D., Jersey City

Premature delivery from all causes is the major cause of perinatal mortality. This paper presents a discussion of the etiologic factors concerned in the onset of premature labor as well as present concepts of management of threatened premature labor, premature labor, delivery, and after care of the premature infant.

2:00 p.m.

The Prevention of Fetal Loss from Blood Group Incompatibility Between Mother and Child

Louis K. Diamond, M.D., Associate Professor of Pediatrics, and Director, Blood Grouping Laboratory, Harvard Medical School, Boston, Mass.

Discussor: Harry B. Lochhead, M.D., Woodbury

It does not seem practical to prevent fetal loss from blood group incompatibility between mother and child by eugenics. It therefore becomes important to prevent sensitization of the prospective mother against blood factors her husband or child might have or to help the anemic child born to the sensitized woman.

It is important to avoid unnecessary blood transfusions or blood injections, especially any unmatched for the important blood factors, before marriage and after marriage before any pregnancy occurs.

The problem of stillbirth in many sensitized women remains difficult. The factors influencing this will be discussed.

With regard to the infants born alive, at present over 90 per cent can be saved with no residual damage.

2:55 p.m.

Preventing Habitual Abortion

Carl T. Javert, M.D., Director of Obstetrics and Gynecology, Woman's Hospital, New York, N. Y.

Discussor: Gerald W. Hayes, M.D., East Orange

A systematic program of preconceptional, prenatal care including psychosomatic therapy has been found to be effective in the prevention of abortion in a selected group of 500 patients. Some of these were normal, while the majority had sterility, habitual abortion and Rh problems. The preventive program resulted in the delivery of viable offspring in 80 per cent of the habitual abortion patients. They had previously aborted 92 per cent of their pregnancies. This approach can be expected to reduce the presently accepted abortion rate of 10 per cent to a lower figure. Study of 2000 abortion cases indicated that one in five was salvageable at the time of the abortion. Measures begun early enough should salvage some of the remaining 80 per cent who were dead at the time of the abortion.

3:25 p.m.

Obstetrical Analgesia, Anesthesia, and Fetal Distress

Gene Zaino, M.D., Associate in Anesthesiology, Muhlenberg Hospital, Plainfield

Discussor: Percy L. Smith, M.D., Trenton

This is a diagramatic presentation of obstetrical analgesics and anesthetics in present day practice. The speaker will emphasize the safety factors in the selection and administration of drugs. Injudicious use of analgesics, and improper technic exert a depressing effect upon the fetus. The problem of fetal and neonatal distress arises, and the resuscitative management of such cases is discussed.

3:50 p.m.

Business Meeting

Nominating Committee

Saturday Evening, April 27, 1957

Chairman, Vincent P. Butler, M.D., Immediate Past-President

8:30 p.m.

Bakewell Room, 1st floor

County	*Delegate*	*Alternate*
Atlantic	David B. Allman	G. Ruffin Stamps
Bergen	G. Barton Barlow	Frederick G. Dilger
Burlington	E. Vernon Davis	R. Winfield Betts
Camden	Frank J. Hughes	Edmund C. Hessert
Cape May	George M. Brooks	
Cumberland	Carl N. Ware	Mary Bacon
Essex	Marcus H. Greifinger	William W. Cox
Gloucester	Louis K. Collins	John J. Laurusonis
Hudson	Joseph P. Donnelly	Aloysius P. Rieman
Hunterdon	Lloyd A. Hamilton	Raymond J. Germain
Mercer	George A. Corio	Raymond A. McCormack, Jr.
Middlesex	Charles H. Calvin	Edward F. Klein
Monmouth	Daniel F. Featherston	Louis F. Albright
Morris	Stanley Teskey	Francis J. Benz
Ocean		
Passaic	Joseph E. Mott	Joseph M. Keating
Salem	C. Spencer Davison	Harry W. Fullerton
Somerset	George E. Barbour	Runkle F. Hegeman
Sussex	Dorsett L. Spurgeon	Robert A. Weinstein
Union	Lorrimer B. Armstrong	Louis S. Wegryn
Warren	Ralph M. L. Buchanan	Volmar A. Mereschak

House of Delegates

President, Lewis C. Fritts, M.D., Somerville

Secretary, Marcus H. Greifinger, M.D., Newark

Parliamentarian, Robert M. Backes, Trenton

Sergeants-at-Arms, Benjamin F. Lee, M.D., Camden
George A. Corio, M.D., Trenton

The Committee on Credentials will meet at the Registration Desk each morning of the meeting.

Vernon Room, Lounge floor

SESSIONS

First Session: 2:30 p.m., Saturday, April 27, 1957

1. Call to Order
2. Invocation
   Reverend Arthur McKay Ackerson, All Saints Episcopal Church, Atlantic City
3. Organization of the House
4. Transactions of 1956 Annual Meeting
5. Introduction of Guests and Delegates from Other States
6. Annual and Supplemental Reports
7. New Business
8. Announcements

Second Session: 4:00 p.m., Sunday, April 28, 1957

1. Report of Nominating Committee
2. Election

Third Session: 10:00 a.m., Monday, April 29, 1957

1. Reports of Reference Committees
2. Unfinished Business
3. Installation of Incoming President
4. Adjournment

Reference Committees

Sunday Morning, April 28, 1957

11:00 a.m.

Reference Committee "A"

Room 1333, 13th floor

Reports of the:

- President
- Board of Trustees
- Secretary
- Judicial Council
- Executive Officer

Reference Committee "B"

Room 1344, 13th floor

Reports of the:

- Treasurer
- Finance and Budget Committee
- Publication Committee
- Medical Student Loan Fund Special Committee

Reference Committee "C"

Mandarin Room, 13th floor

Reports of the:

- Medical Service Administration of New Jersey
- Medical-Surgical Plan of New Jersey

Reference Committee "D"

Room 1335, 13th floor

Reports of the:

- Medical Education Committee
- Medical Defense and Insurance Committee
- Special Committees on:
  - Emergency Medical Service Civil Defense
  - Physicians Placement Service
  - Widows and Orphans of Medical Men

Reference Committee "E"

Room 1337, 13th floor

Reports of the:

- Welfare Committee
- Subcommittees on:
  - Legislation
  - Medical Practice
  - Public Health
  - Public Relations
- Special Committees on:
  - Cancer Control
  - Chronically Ill
  - Conservation of Hearing and Speech
  - Conservation of Vision
  - Industrial Health
  - Maternal and Infant Welfare
  - Mental Health
  - Rehabilitation
  - Routine Health Examination
  - School Health
  - Workmen's Compensation

Reference Committee on Constitution and By-Laws

Bakewell Room, 1st floor

To consider:

- Amendments to the Constitution
- Amendments to the By-Laws

Reference Committee on Miscellaneous Business

Rowsley Room, 1st floor

Reports of the:

- Annual Meeting Committee
- Subcommittees on:
  - Scientific Program
  - Scientific Exhibit
- Advisory Committee to the Woman's Auxiliary

Reference Committee on Resolutions and Memorials

Room 1332, 13th floor

To consider:

- Nominations for Honorary Membership
- Nominations for Emeritus Membership
- Resolutions
- Memorials

Reference Committee on Credentials will meet at the Registration Desk each morning of the meeting

30th Annual Meeting

Woman's Auxiliary

To The Medical Society of New Jersey

Chalfonte, Atlantic City

April 28, 29, 30, and May 1, 1957

Daily Schedule

Sunday, April 28, 1957

10:00 a.m.—Registration Opens — Breakfast and Luncheon Tickets

Parlor, Lounge floor

Dinner Tickets
Sun Porch, Lounge floor, Haddon Hall

1:00 p.m.—Art Exhibit Opens

Gallery, Lounge floor

6:30 p.m.—Fellowettes' Dinner

Zodiac A, Lounge floor

Monday, April 29, 1957

10:00 a.m.—Registration—Breakfast and Luncheon Tickets

Parlor, Lounge floor

Dinner Tickets
Sun Porch, Lounge floor, Haddon Hall

10:30 a.m.—Pre-Convention Board Meeting

Roberts Room, Lounge floor

3:30 p.m.—Tea—All physicians' wives are cordially invited. Entertainment by courtesy of the Camden Auxiliary Dramatic Group

Music Room, Lounge floor

8:00 p.m.—General Session of the 191st Annual Meeting of The Medical Society of New Jersey—The members of the Woman's Auxiliary are invited to attend.

Viking Room, 13th floor, Haddon Hall

Tuesday, April 30, 1957

9:00 a.m.—Registration—Breakfast and Luncheon Tickets

Parlor, Lounge floor

Dinner Tickets

Sun Porch, Lounge floor, Haddon Hall

General Session

Music Room, Lounge floor

12:30 p.m.—Luncheon

Carolina Room, Lounge floor

2:30 p.m.—General Session (reconvenes)

Music Room, Lounge floor

7:00 p.m.—Dinner-Dance

Vernon Room, Lounge floor, Haddon Hall

Wednesday, May 1, 1957

9:00 a.m.—Inaugural Breakfast

Roberts Room, Lounge floor

10:00 a.m.—Post-Convention Board Meeting

Roberts Room, Lounge floor

There will be an instruction session for new State Officers, Chairmen, and County Presidents immediately following the close of the Board Meeting.

12:00 noon—President's Luncheon for Incoming County Presidents

Zodiac A, Lounge floor

Hospitality Room—Vaux Hall, Lounge floor
Exhibit of County Scrap Books—Vaux Hall, Lounge floor
Art Exhibit—Gallery, Lounge floor
Golf Matches—Atlantic City Country Club

SCIENTIFIC EXHIBITS

Lounge Floor

Exhibit Hours: 9:00 a.m. - 5:00 p.m., Monday and Tuesday, April 29 and 30, 1957
9:00 a.m. - 3:00 p.m., Wednesday, May 1, 1957

Booth 1. Testing the Drinking Driver—Bureau of Traffic Safety, New Jersey State Department of Law and Public Safety, Trenton

The alcohol factor in traffic accident causation. Demonstration and explanation of "breath" test—Harger Drunkometer.

Booth 2. Psychiatric Facilities in General Hospitals—Division of Mental Health and Hospitals, New Jersey State Department of Institutions and Agencies, Trenton

Data will be presented to show the advantages of psychiatric units in general hospitals in the management of serious mental illnesses. These advantages will be shown in terms of increased convenience and comfort to the patient, decrease in duration of disability, less disruption of family social and economic activities, and over-all decrease in cost of medical care. The exhibit will also point up advantages to the hospital and medical staff which such a unit offers.

Booth 3.—Chronic Illness Control—Division of Chronic Illness Control, New Jersey State Department of Health, and Committee on the Chronically Ill, The Medical Society of New Jersey, Trenton

Emphasizing the new concept that something can be done, and is being done, about chronic illness; and effective ways and means of assisting the general practitioner to carry out his expanding role in the prevention, early detection and control of chronic illness and the rehabilitation of the chronic sick.

Booth 4. Prematurity—New Jersey State Department of Health, Trenton

This exhibit deals with the New Jersey State Department of Health approach to prematurity and illustrates these features: Hospital Training Program in Care of Premature Infants, Information Service and Equipment Loan Service.

Booth 5. Opportunities Offered for the Postgraduate Training of Part-Time Anesthesiologists—Irving R. Hayman, M.D., Chairman, New Jersey Society of Anesthesiologists, Paterson

Booth 6. Visual Field Screening Test for Glaucoma and Other Pathology—New Jersey State Commission for the Blind, Newark

The purpose of the exhibit is to demonstrate a visual field screening instrument for the detection of ocular and intracranial pathology affecting the peripheral vision. The emphasis is directed toward glaucoma because 2 per cent of the population over the age of 40 is affected with this blinding eye disease. The peripheral vision is impaired before the central, consequently a visual field examination makes the earliest visual diagnosis.

This instrument will be operated by an ophthalmologist who will perform a visual field screening test on any person who visits the exhibit.

Booth 7. Diagnosis and Treatment of Various Forms of Vaginitis—Joseph G. Stella, M.D., Warren R. Lang, M.D., and Abraham E. Rakoff, M.D., Jefferson Medical College, Philadelphia, Pa.

The exhibit outlines the essential features of the diagnosis and management of the four most common forms of vaginitis: Trichomonas vaginalis vaginitis, Candida albicans vulvovaginitis, nonspecific and atrophic vaginitis. Careful diagnosis is stressed as are principles of management. Mimeographed outlines supplementing and enlarging on the exhibit will be available.

Booth 8. Leritine®—A New Narcotic—Its Use as Analgesic—Intra and Post-operatively—Irving M. Riffin, M.D., Berthold Schwarz, M.D., Milton E. Landman, M.D., Rudolf Preisig, M.D., and Henry Wheaton, M.D., St. Vincent's Hospital, Montclair

Anileridine®, a new narcotic, used to potentiate nitrous oxide anesthesia for major and minor surgery. The exhibit will give the step-by-step technic of its administration. Advantages and disadvantages will be considered. Use of such adjuvants as muscle relaxants, antinarcotics and short-acting barbiturates or cyclopropane to cover the momentary requirements of the surgical procedure. Monitoring of the anesthetic period with electro-encephalographic and electrocardiographic studies revealed the minimal physiologic side effects of Anileridine®. Examples of control and anesthetic graphs will be shown. In addition, a statistical analysis of 500 cases will be presented showing the value of Anileridine® in relation to other common narcotic drugs for post-operative analgesia.

Booth 9. The Differential Diagnosis of Breast Tumors—American Cancer Society, New Jersey Division, Inc, Newark

Photographs of various breast conditions such as adenofibroma, adenosis, cyst, fat necrosis, Paget's Disease, and carcinoma are shown under the headings of differential gross signs, gross pathology and microscopic pathology. Diagnostic characteristics and treatment are listed. The technic of breast examination by the physician is described.

Booth 10. Arterial Grafts—Factors Involved in Success or Failure—Norman Rosenberg, M.D., John Henderson, M.D., E. R. L. Gaughran, Ph.D., J. H. Lord, D. V. M., Ph.D., and J. F. Douglas, Ph.D., Middlesex General Hospital, and St. Peter's General Hospital, New Brunswick

This exhibit attempts to analyze the factors leading to success or failure of arterial grafts and prostheses. Information is presented on the physical properties of the elastica and collagen components of the vessel wall, these tissue elements being isolated by a process of enzymatic dissection. Both acceptable and experimental arterial substitutes are demonstrated. Causes for graft failure, and degenerative changes leading to poor results, are illustrated in some detail.

Booth 11. Pathology of Lung Expansion in the Newborn—Peter Gruenwald, M.D., and Joseph P. Donnelly, M.D., Margaret Hague Maternity Hospital, Jersey City

This is a study of pulmonary factors concerned with difficulties of air breathing in the newborn. Accidents of pulmonary expansion include intrauterine aspiration of vernix, and postnatal rupture of lungs. In addition, the pattern of aeration of any lung is influenced by surface tension. In prematures in particular this produces a characteristic pattern of atelectasis. The relation of this atelectasis of prematures to hyaline membranes is presented. Finally, a simple method is suggested for examination of lungs in perinatal pathology by means of inflation with fluid and air.

Booth 12. Pseudohypoparathyroidism—Nathaniel Finby, M.D., Joseph V. Cusmano, M.D., and David H. Baker, M.D., New York Hospital-Cornell Medical Center, New York, N. Y., and Englewood Hospital, Englewood

The roentgen features in six patients with pseudohypoparathyroidism will be reviewed. The chief features are: shortening of the metacarpals and metatarsals, intracranial calcification, soft tissue calcification and thickening of the calvarium.

Booth 13. Nutritional Cirrhosis — Carroll M. Leevy, M.D., Thomas J. White, M.D., Angelo M. Gnassi, M.D., and Felix Traugott, Medical Center, Jersey City

This exhibit reviews observations on the histogenesis, biological effects, and results of treatment in hepatic cirrhosis due to poor dietary habits, with and without alcoholism. It is based on serial clinical, biochemical, and histological studies in 250 patients with this disease over a ten-year period. Nutritional cirrhosis was classified into mild, moderate, and severe degrees based on the amount of fibrosis, and the degree of dissociation or regenerated parenchymal cells from the vascular and biliary systems. The exhibit will include (1) anatomical reconstructions from serial liver biopsies which trace the transition of fatty liver to cirrhosis and demonstrate the importance and interrelations of fibrosis and nodular regeneration of liver cells in architectural distortion; (2) pathophysiology of major clinical and functional abnormalities, effects of decreased hepatic reserve on body homeostasis, and reactivity to stress of surgery, infections, and intercurrent illness; (3) correlation of portal pressure, fluid compartments, hormonal assays, blood clotting abnormalities, and mental changes with functional reserve and histology; (4) overall prognosis and the value of current therapy on specific clinical, biochemical, and histological changes.

Booth 14. Blood Volume Determination Using Radioactive Iodinated Human Serum Albumin—Department of Radiology, Vincent M. Whelan, M.D., and Andrew P. Dedick, Jr., M.D.; Department of Medicine, Frank J. Altschul, M.D., and Joel Feldman, M.D.; Department of Surgery, Harold A. Kazmann, M.D., Monmouth Memorial Hospital, Long Branch

The knowledge of blood volume status is perhaps more important than red cell count, hematocrit, and hemoglobin determination, and gives information that cannot be obtained by these means. This exhibit shows a simplified technic of determining total, blood volume, plasma volume, and red cell mass, based on the dilution principle. Clinical correlation between hematocrit, hemoglobin, red cell count, and blood volume will be demonstrated along with important applications of clinical cases.

Booth 15. Home Accident Prevention—Walter B. Stewart, M.D., and Samuel C. Southard, M.D., New Jersey Chapter, American Academy of Pediatrics, Atlantic City

The four most common causes of home accidents in childhood are burns, falls, poisoning, and firearms. Protection of the child must be featured up to five years, and education thereafter. The National Safety Council reports 6,950 home accident deaths in 1955, in children from zero to 14 years of age.

Booth 16. Vocational Rehabilitation—New Jersey Rehabilitation Commission, Trenton

The New Jersey Rehabilitation Commission exhibit briefly outlines, through pictures and posters, the work of the Commission in returning mentally and/or physically disabled workers to the fullest mental, vocational, social, and economic usefulness of which they are capable.

Vocational rehabilitation is not charity. It is a public service for the disabled of New Jersey comparable to public education, public health and other activities for the welfare of the people.

Booth 17. Oral Treatment of Diabetes Mellitus —A Clinical and Pharmacologic Study—Herbert S. Kupperman, M.D., and Marvin C. Becker, M.D., Newark

Purpose of the exhibit is to discuss the selection of patients, clinical management, and therapeutic results with tolbutamide in the oral treatment of diabetes. It serves to introduce an intravenous diagnostic test used to predict the patient's response to tolbutamide as an aid in the selection of patients.

Controlled pharmacological studies relative to the metabolic effects of the drug are presented.

Booth 18. Effect of Metisteroids in Toxemia in Vitro and in Vivo—H. Seneca, M.D., O. K. Troc, M.D., and R. Scheuer, M.D., Columbia University College of Physicians and Surgeons, and Columbia-Presbyterian Medical Center, New York, N. Y.

Metisteroids prolong the life of experimentally induced toxemia by the exotoxins of Corynebacterium diphtheriae, Clostridium tetani and Clostridium welchi and Micrococcus pyogenes aureus. In vitro findings indicate that metisteroid solutions (Hemisuccinate) protect erythrocytes against hemolytic doses of tetanolysin and staphylococcus hemolysin.

Booth 19. Clinical Significance of Serum Ammonium Levels in Liver Disease — Abraham L. Friedman, M.D., and Vincent H. Gillson, M.D., Bergen Pines County Hospital, Paramus

Serum ammonium levels have been investigated in various diseases of the liver, particularly portal cirrhosis. Elevations were found consistently in hepatic coma but no specific levels associated with coma could be determined. A comparison of arterial and venous ammonium revealed a much closer correlation between coma and arterial levels than with venous levels. Serum ammonium levels were determined following the administration of ammonium chloride in patients with and without porta-caval shunt, high protein diets, protein hydrolysate infusions, methionine and diamox. Photomicrographs of liver tissue obtained by biopsy or necropsy will be correlated with serum ammonium and other laboratory findings.

The physiology of serum ammonium and its relation to the Krebs cycle are illustrated. Finally the effect of glutamic acid on serum ammonium levels, arterial and venous are shown.

Booth 20. Cardiac Resuscitation—Anthony D. Crecca, M.D., Joseph V. Crecca, M.D., John J. McGuire, M.D., Lucien G. Massarelli, M.D., and Thaddeus A. Balinski, M.D., St. Michael's Hospital, Newark

Cardiac emergencies arising during the administration of anesthesia and during surgery are the chief causes of operating room deaths. An understanding of the physiological principles in the causation of these emergencies is of prime importance. The prompt institution of an organized approach to such emergencies based on a knowledge of the mechanisms involved and the methods of prevention and treatment of such catastrophies is vital to the intelligent management of such problems.

Booth 21. Management of Vesicovaginal Fistula —Henry C. Falk, M.D., Beth Israel Hospital, New York, N. Y.

The various types of vesicovaginal fistula — postpartum—total abdominal hysterectomy — after cesarean section and loss of urethra with vesicovaginal fistula are shown using enlargements of original drawings. The drawings show the various steps in the repair of these fistulas including the technic of reconstruction of the urethra and vaginal cystotomy.

Booth 22. The Significance of Melituria in Pregnancy—Milton Gross, M.D., Robert E. Sexton, M.D., and Robert I. Dorian, M.D., Margaret Hague Maternity Hospital, Jersey City

Periodic urine examinations were made in over 800 normal pregnant out-patients of the Margaret Hague Maternity Hospital clinic. Reducing substances (Benedict's Urine Sugar Test), glucose (Glucose oxidase Testpapers) and ketones (Rothera Test) were determined. In this exhibit, the physiology of melituria in pregnancy is presented diagrammatically. This melituria has been regarded as common, usually benign, and probably due either to lactose or to a reduction in the apparent renal threshold for glucose. Clinical and laboratory evidence is provided in charts and graphs which suggests that, frequently, true glycosuria in an otherwise symptom-free pregnant woman may be indicative of an underlying defect in carbohydrate metabolism exposed by the strain of pregnancy. A higher incidence was found in women with true glycosuria of such factors generally associated with diabetes mellitus as obesity, ketonuria, abnormal parturition, increased fetal size and fetal wastage.

Consequently, periodic examination for true glycosuria should be routine procedure during the prenatal period. This test is now facilitated by glucose specific test-papers (Tes-Tape®—Lilly; and Clinistix®—Ames) which have proved convenient for the differentiation of glucose from the other reducing substances often present in the urine of pregnant women.

Booth 23. Cardiac Surgery—Long Term Results —Houck E. Bolton, M.D., and Charles P. Bailey, M.D., Bailey Clinic, Philadelphia, Pa.

A large series of patients have been operated upon for acquired valvular heart disease. The follow-up study of these patients is an interval of as long as nine years since surgery. The results of surgery will be evaluated. The series includes patients operated upon for both stenotic as well as incompetent valvular lesions, treated either as isolated or multivalvular lesions.

Another group of patients who have had coronary arterial endarterectomy for coronary thrombosis will be presented.

Booth 24. The Hemiplegic Rehabilitation Process—Charles R. Brooke, M.D., Thomas J. D. Scanlan, M.D. and Gilbert A. Guarino, M.A., Veterans Administration Hospital, East Orange

The exhibit is designed to demonstrate graphically the effect of cardiovascular accidents on the cardinal functional capacities of the individual expressly in the areas of ambulation, communication, manual dexterity and emotional balance. The exhibit further depicts those ingredients which are employed in an effort to achieve a cure. In the last panel of the

exhibit, an effort is made to define what is functional cure as it applies to the hemiplegic patient. In brief, all efforts of the rehabilitation process do not lead to a complete re-establishment of the patient's physical and psychological powers, but instead imply the development of the patient's optimum physical and mental ability within the highest limits imposed by the CVA.

Booth 25. Selected Cutaneous Tumors of Childhood —Harold W. Dargeon, M.D., and Charlotte Tan, M.D., Children's Tumor Registry and Pediatric Service, Memorial Center, New York, N. Y.

A variety of pigmented tumors occur during the juvenile age period, most of which are histologically benign. Their size, location and growth — evident and potential—determine their clinical importance. Examples of angioma, nevi, melanoma, xanthoma, neurofibroma, carcinoma, leukemia and reticuloendothelioses are shown in the exhibit and the therapy is described.

Booth 26. Audiology and Community Health —The Henry C. Barkhorn Hearing and Speech Center, Newark Eye and Ear Infirmary, Newark

This exhibit illustrates pictorially the function of audiology in four stages: (1) instruments; (2) clinical tests as related to otological findings; (3) post-medical rehabilitation, when and how, and, (4) industrial audiology.

Booth 27. Safe Cerebro-Electrotherapy Theodore R. Robie, M.D., Orange Memorial Hospital, Orange, and Veterans Administration Hospital, Lyons

An educational motion picture demonstrating the comparison of the older method of giving electroconvulsive treatment without anesthesia or muscle relaxants, compared to the present method which gives both safety to the patient and the elimination of pretreatment anxiety through the use of the newest quick-acting barbiturate anesthetic, Neraval®, and succinyl choline chloride (Anectine®) as muscle paralyzing agent.

Booth 28. Congeners — Meaning — Analysis — House of Seagram, New York, N. Y.

Congeners (fusel oil, aldehydes, *et cetera*) are elements which appear in all alcoholic beverages, providing them with flavor and bouquet. In high concentration, they may produce undesirable side effects. This exhibit, based on analyses by Foster D. Snell, Inc., independent consulting chemists, shows how the congeneric contents of leading popular brands of alcoholic beverages vary in amount. The physician who advises his patient to drink in moderation can be guided by the results of these analyses in suggesting the type of alcoholic beverage which is lowest in congeners.

Booth 29. TSC—Performance Test of a Therapeutic Scalp Cleanser — Irving Shapiro, M.D., Newark

A new lotion containing polythionate and detergent has been tested for two years using 100 patients having complaints of resistant scalp scaling, redness, itching and burning.

Results indicate relief in 97 per cent within 1 to 3 weeks and lasting from 3 weeks to 9 months. Sensitization has not been seen, the side actions are minimal and harmless and there is no danger of toxic absorption.

Appropriate charts, tables, sketches and before-and-after photographs illustrate the clinical results.

Booth 30. Bilateral Adrenalectomy for Metastatic Mammary Carcinoma — Victor Parsonnet, M.D., Newark Beth Israel Hospital, Newark

Outlined here are indications for the selection of patients and technics for determination of estrogen dependence. Also presented are pre-operative and postoperative methods of steroid therapy and an overview of the surgical approach. Clinical results are summarized. Also offered are details of two cases where there was absolutely no evidence of active residual disease 22 months after bilateral adrenalectomy. The exhibit includes charts, checklists, posters, photographs and drawings.

Booth 31. An Evaluation of C-reactive Protein and S-GO Transaminase in Coronary Artery Disease —Irving G. Kroop, M.D., and Nathan H. Shackman, M.D., Jewish Chronic Disease Hospital, Jewish Hospital, and State University College of Medicine, Brooklyn, N. Y.

A positive C-reactive protein test and an elevated S-GO transaminase level are consistently found in transmural infarction. The C-reactive protein was negative and transaminase levels normal in 36 patients with symptomatic coronary disease without myocardial necrosis. Serial determinations will demonstrate that the transaminase levels were not diagnostic in 29 out of 45 cases of myocardial necrosis with only RS-T and T wave changes. The C-reactive protein test was positive in these as well as in the 16 cases where both tests agreed and were diagnostic of myocardial necrosis. The C-reactive protein determination is more sensitive than the transaminase determination in the diagnosis of mild myocardial necrosis, but cannot be used unless all extracardiac stimuli for its formation are absent.

Booth 32. Analysis of a Random Sampling of Electrocardiograms in a Psychiatric Hospital — Nathan Frank, M.D., Thomas J. White, M.D., Martin W. Pollini, M.D., Mustafa Naama, M.D., Jan Herchold, M.D., and George P. T. Lim, Hudson County Hospital for Mental Diseases, Secaucus

Aim of this exhibit is to demonstrate the value of routine electrocardiograms in mental patients. A statistical analysis of the various electrocardiographic abnormalities and heart disease in a series of mental patients is presented. This study shows that heart disease is a concomitant finding in a large number of psychotic patients in whom no previous history of cardiac disease was obtainable.

TECHNICAL EXHIBITS

Lounge Floor

Exhibit Hours: 9:00 a.m. - 5:00 p.m., Monday and Tuesday, April 29 and 30, 1957
9:00 a.m. - 3:00 p.m., Wednesday, May 1, 1957

Booth A. The Borden Co., New York. The Prescription Products Division of The Borden Co., makers of Mull-Soy® for the allergic infant, and Bremil® for the normal infant, invite all guests of the convention to visit its Coffee Lounge located in booth A on the convention floor.

Booth 1. Medical-Surgical Plan of New Jersey, Newark. Medical-Surgical Plan of New Jersey — "New Jersey Blue Shield Plan"—was organized at the direction of The Medical Society of New Jersey in 1942, and is approved by the Society and its 21 component county societies.

"Blue Shield," a cooperative community enterprise representing a partnership between 5,463 Participating Physicians and more than 1,546,000 enrolled citizens of New Jersey, is dedicated to the proposition that doctors and their patients can solve their mutual economic problems through voluntary efforts.

We cordially invite all physicians and their guests to visit our display which has been prepared by the staff of Medical-Surgical Plan and will be manned by representatives of the Professional Relations Department.

Booth 2. E. & W. Blanksteen, Jersey City. Information and literature are available at this booth regarding The Medical Society of New Jersey plan of accident and health insurance.

Booth 3. Faulhaber & Heard, Inc., Newark. Information may be obtained on professional liability protection upon inquiry at booth 3 maintained by your Official Broker, Faulhaber & Heard, Inc.

Protection is also available for professional assistants such as registered or graduate nurses, and x-ray or laboratory technicians.

Booth 4. Encyclopaedia Britannica, Inc., Philadelphia. The new edition of Encyclopaedia Britannica will be displayed as part of a special exhibit offer. The 1957 edition is the work of 5565 of the world's best minds from 75 countries. The offer available is for the duration of the 191st Annual Meeting, and cannot be made in the home or office on the same basis after the close of the meeting.

Booth 5. Thomas A. Edison Industries of McGraw-Edison Co., West Orange. Edison will introduce its newest product, the "All-Purpose" Voicewriter. You can use it for dictating and transcribing, in or out of the office. It will serve also as a remote-controlled recorder with your dial telephones or Edison dictating phones! In each of its uses, the instrument offers the facility of superior single-purpose machines.

Remarkably versatile, the instrument readily adapts to changing requirements. A doctor-secretary team can use it now individually. Later, if more doctors practice in the same office, this same Voicewriter will record telephone dictation for all of them.

Booth 6. Blair Laboratories, Inc., Short Hills. Isadoxol®, a unique concept in the treatment of constipation, combines the softening effect of dioctyl sodium sulfosuccinate with a minimum dose of the non-absorbed peristaltic stimulant Diace®, (diacetyldihydroxyphenylisatin, Blair) an analogue of the laxative factor in prunes.

The reciprocal action of Isadoxol® results in a normal, well-formed stool overnight in most patients without the discomforting side effects of high laxative doses. Blair representatives will also discuss Doxol®, the original high-potency (100 mg.) dioctyl sodium sulfosuccinate.

Booth 7. Sandoz Pharmaceuticals, Hanover. Bellergal Space Tabs®—assures around the clock control of functional complaints (example—menopause symptoms) in the periphery where they originate.

Cafergot PB®—the most effective oral medication for the relief of migraine headache with gastrointestinal disturbance accompanied by tension.

Sandostene®—an antihistaminic with powerful anti-permeability action useful in the treatment of itching, asthma, *et cetera*.

Booth 8. Nordmark Pharmaceutical Laboratories, Inc., Irvington. New iron therapy—Ferronord® tablets, a brand of ferroglycine sulfate complex iron—will be featured. Extensive research has developed an aminoacetic complex of iron which supplies ferrous ions protected against oxidation in pH ranges of stomach and intestine. Ferronord® provides for: (1) Optimal absorption of ferrous iron; (2) Freedom from the side effects usually associated with iron therapy; (3) Rapid increase of serum iron levels in days; (4) Correspondingly higher hemoglobin levels in days.

So well tolerated, Ferronord® should be given on an empty stomach, or between meals, for optimal absorption.

Booth 9. Thermo-Fax Sales, Inc., New York. The new Thermo-Fax "Secretary" Copying Machine can put out five hundred monthly statements for doctors in only two hours. The "Secretary" Copying Machine is the world's only all electric, non-chemical copying machine and affords the medical profession the world's fastest and easiest copying process. The dozens of uses include keeping laboratory reports, bills, technical data, prescriptions, and depositions to insurance companies. This model is the latest development of the research facilities of Minnesota Mining & Manufacturing Company.

Booth 10. E. R. Squibb & Sons, New York. E. R. Squibb & Sons has long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the medical profession in new products or improvements in products already marketed.

At Booth 10, we are pleased to present up-to-date information on these advances for your consideration.

Booth 11. Ames Company, Inc., Elkhart, Indiana. The Ames exhibit will introduce a new and unique concept in sedation—a new calmative drug—Nostyn®. This is chemically and physiologically unrelated to any now available compound. Nostyn® allays anxiety and tension with the power of gentleness; possessing a wide margin of safety, Nostyn® avoids depression or drowsiness.

Booth 12. Milex of New York, Long Island City, N. Y. The Milex Cancer Detection Program will be featured at booth 12. This consists of the latest developments for vaginal, cervical, and endometrial smears and biopsies, and for new vaginal and cervical speculae. Also featured are the superior Crescent Diaphragm and the Milex Folding Pessaries. Lestens®, for premenstrual tension, is a completely rounded attack against this syndrome and includes progesterone.

Booth 13. Johnson & Johnson, New Brunswick. You are cordially invited to the Johnson & Johnson booth, where you will find the most recent developments in surgical dressings and baby products. In addition to these products (some of which are well known and many of which are new) you will find a display of Johnson's Fashion Sheer Elastic Hosiery. This new product combines the advantages of excellent support demanded by the physician and the comfort and fashion features which are appreciated by the patient. Representatives will be pleased to discuss any of these products with you or to be of service in any way.

Booth 14. Picker X-Ray Corporation, White Plains, N. Y. "Dial-the-part" automation distinguishes the new Picker Anatomatic Century II x-ray unit. Simple to use, it eliminates the need for technic charts or manual setting of separate technic factors. The operator merely "dials" the body part, makes a simple thickness-of-part setting, and pushes a button for the exposure. Coupled with this control is a new full size motor-driven table with a single x-ray tube quickly changed over from fluoroscopy to radiography.

Booth 15. The Coca-Cola Company, Atlanta. Ice-cold Coca-Cola will be served through the courtesy and cooperation of the Coca-Cola Bottling Company, Atlantic City, New Jersey and The Coca-Cola Company.

Booth 16. G. D. Searle & Co., Chicago. You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be Nilevar®, the new anabolic agent; Rolicton®, the new safe, non-mercurial oral diuretic; Vallestril®, the new synthetic estrogen with extremely low incidence of side reactions; Banthine® and Pro-Banthine®, the standards in anti-cholinergic therapy; and Dramamine®, for the prevention and treatment of motion sickness and other nauseas.

Booth 17. The National Drug Co., Inc., Philadelphia. The National Drug Company presents products of original research at Booth 17. These "National" specialties include Parenzyme® (intramuscular trypsin) the direct, anti-edema, anti-inflammatory agent. The efficacy of Parenzyme® is clinically substantiated for the treatment of traumatic wounds, skin ulcers, ophthalmic inflammations, thrombophlebitis, phlebothrombosis and in bronchial conditions involving thick and tenacious secretions. Hesper-C Prenatal®, a precaution in normal pregnancy and a necessity in habitual abortion is the only complete preparation with hesperidin and ascorbic acid as capillary protective factors plus established prenatal vitamin and mineral supplementation. Sominat, the first analgesic hypnotic is also featured.

Booth 18. Ayerst Laboratories, New York. A most cordial invitation is extended to all physicians to visit Ayerst Laboratories' Booth 18 where our representatives will be on hand to discuss with you any products that you may desire information on.

Booth 19. A. H. Robins Company, Inc., Richmond, Va. The A. H. Robins Company exhibit spotlights Donnatal®. This "most prescribed" of all antispasmodic-sedatives is available not only in tablets, capsules and palatable elixir, but also in long-acting Extentabs®. Also featured: Allbee® with C, capsules providing "saturation dosage" of B complex factors and ascorbic acid: Donnagesic Extentabs®, extended action tablets of codeine with Donnatal® for 10-12 hour analgesic effects on a single dose; Entozyme®, comprehensive digestive enzyme supplement; and Robalate® (dihydroxy aluminum aminoacetate), antacid available in tablets and the new light-bodied Robalate® Liquid.

Booth 20. American Ferment Co., Inc., New York. Stop at the booth for your personal supply of Falgos®, the buffered compound analgesic that acts quickly and without gastric upset. Let us also explain the advantages of Caroid and Bile Salts Tablets®, Alcaroid Antacid®, and Supligol®, the whole-bile-ketocholanic acid compound.

Booth 21. Eli Lilly and Company, Indianapolis. You are cordially invited to visit the Lilly exhibit located in Booth 21. The display will contain information on recent therapeutic developments. Lilly sales people will be in attendance. They welcome your questions about Lilly products.

Booth 22. The C. V. Mosby Company, St. Louis. Visitors to the convention are cordially invited to browse through the Mosby exhibit in Booth 22. There will be found more than 20 new books and new editions in the field of medicine and surgery.

Of particular interest should be Sodi-Pallares *New Bases of Electrocardiography,* Meakins *Practice of Medicine,* Bard *Medical Physiology,* Forster *Modern Therapy in Neurology,* and Lisser-Escamilla *Clinical Endocrinology.*

Booth 23. Hoffmann-La Roche, Inc., Nutley. Vi-Penta® Drops are now available in three different forms. Vi-Penta® No. 1 is for premature and full-term infants during the first week of life. Vi-Penta® No. 2 is for infants during the first year of life. Vi-Penta® No. 3 is for infants and children of all ages.

Gantrimycin® combines Gantrisin® and oleandomycin for use in a wide variety of bacterial infections.

Lipo Gantrisin® is a long-lasting antibacterial which usually maintains effective blood levels on only two doses a day.

Booth 24. Mead Johnson & Company, Evansville, Ind. In the Mead Johnson booth, specially trained representatives will be ready to tell you about these product "families": (1) The Mead Johnson Formula Products Family — including ready-to-use Lactum® and Olac® for routine infant feeding, as well as Dextri-Maltose®; (2) The Deca Vitamin® Family—3 convenient dosage forms for comprehensive vitamin protection of infants and children; (3) The Colace® Family — providing a new approach in preventing and treating constipation by keeping stools soft for easy passage.

Booth 25. L & L Surgical Supply, Inc., Newark. The L & L Surgical is a new name but it represents two of the oldest firms in the state: the Lissco Medical Company and the Livezey Surgical —they have merged into one bigger company. In their books you are bound to see at least one item that will be brand new, never shown before by anybody, and also many interesting and useful appurtenances.

Booth 26. The Purdue Frederick Company, New York. The Purdue Frederick Company will feature: Senokot® Tablets and Granules — new non-bulk, non-irritating constipation corrective acting selectively on the parasympathetic (Auerbach's) plexus in the large bowel, physiologically stimulating the neuromuscular defecatory reflex. Pre-Mens®—the multidimensional premenstrual tension therapy. Somatovite®—clinically proved to promote weight gain, increase appetite and reduce hyperactivity and restlessness. Sippyplex®—the modern comprehensive therapy for peptic ulcer.

Booth 27. Saratoga Springs Authority, Saratoga Springs, N. Y. How the New York State-owned Saratoga Spa serves the physician and the patient is completely explained in this new exhibit. Changing cards tell the story of mineral baths and other types of treatments with naturally carbonated mineral water, controlled diets, exercise, rest and relaxation, and the Spa's many year 'round attractions. A booth attendant will take registrations and dispense information and literature. (Member of the Association of American Spas)

Booth 28. Nepera Chemical Co., Inc., Yonkers, N. Y. The Nepera exhibit features Mandelamine®, a chemical combination of methenamine and mandelic acid; a specific, well tolerated antiseptic in urinary tract infections, particularly those of a chronic or recurrent type.

Also featured—Choledyl®, which has been highly effective in the treatment of bronchial asthma, bronchospasm and congestive heart failure. Choledyl® assures high oral theophylline blood levels, with minimal side reactions; it rarely produces fastness.

Biomydrin® Nasal Spray, for effective mucolytic-penetrating antibacterial activity, prolonged nasal decongestion and antiallergic effect.

Booth 29. Warner-Chilcott Laboratories, New York. A visit to the Warner-Chilcott booth will pay dividends, especially in the interests of your cardiovascular patients and those with various emotional and psychological disturbances. The company is featuring clinically tested and proved agents to help you prevent attacks of angina pectoris, and to treat many other clinical conditions.

Booth 30. E. Fougera and Co., Inc., New York. E. Fougera & Company, Inc. and Division, Varick Pharmacal Company, Inc., cordially invite physicians to discuss with professional service representatives new preparations of importance to their everyday practice. Descriptive literature and samples of all products will be available.

Booth 31. Ciba Pharmaceutical Products, Inc., Summit. Ciba is featuring two prescription specialties—Ritalin®, a new mild stimulant-antidepressant and Doriden®, a nonbarbiturate hypnotic-sedative. Ritalin® raises depressed patients to normal levels of psychomotor activity without amphetamine-like over-stimulation or depressive rebound. Nonhabit-forming Doriden® is already being widely used as a safe, barbiturate replacement. Representatives will be present to answer queries on these very effective agents.

Booth 32. Bilhuber-Knoll Corporation, Orange. Literature and information concerning the new analgesic Rapacodin® are available for you at our exhibit.

Our representatives invite you to visit our booth 32 to discuss Rapacodin® as well as the antiasthmatic, Quadrinal®, and the other drugs of our manufacture. The results of recent clinical investigations concerning these preparations will be available for your review.

Booth 33. Smith, Kline and French Laboratories, Philadelphia. This year the S.K.F. booth is proud to highlight three new compounds. One, Compazine®, is a true tranquilizer and potent antiemetic with minimal side effects. Another, Sul-Spansion®, is sulfaethylthiadiazole—a safe, soluble sulfonamide in a unique sustained release suspension—indicated for respiratory, urinary tract and other systemic infections. The third is a Duentric®-coated aspirin—Ecotrin®—which makes long-term, high dosage therapy possible.

Thorazine® and Cytomel® are also featured. Stop at the S.K.F. booth; our representatives will be glad to give you literature and information.

Booth 34. Gerber Products Company, Fremont, Mich. When milk is contraindicated as the basic food for infants, Gerber "Meat Base Formula" can provide a nutritionally adequate replacement. It is well accepted and tolerated by infants of all ages. Your Gerber detailman invites you to evaluate "Meat Base Formula" and the complete line of supplementary baby foods.

You are also invited to review new editions of Gerber's baby care booklets. Each is designed especially for distribution by physicians. Each provides non-controversial information in simple, easy-to-understand language. The service is complimentary.

Booth 35. Ortho Pharmaceutical Corporation, Raritan. Ortho cordially invites you to booth 35. Obstetrical and gynecologic pharmaceuticals will be featured. Tritheon Aminitrozole Tablets® for the oral treatment of trichomoniasis in the male and female will be given particular emphasis. Ortho representatives will be happy to meet you and answer any questions you may have on their preparations.

Booth 36. W. B. Saunders Company, Philadelphia. Among the newest titles of most interest are: Campbell: *Urology*; Nadas: *Pediatric Cardiology*; Beierwaltes: *Clinical Radioisotopes*; Tracy: *The Doctor as a Witness*; and a brand new edition of *Dorland's Medical Dictionary*.

Booth 37. Merck Sharp & Dohme, Philadelphia. The Merck Sharp & Dohme exhibit presents highlights on steroid therapy featuring the newer adrenal cortical steroid preparations in endocrine disorders, collagen diseases, respiratory allergies, eye diseases and skin conditions.

Research developments in the field of antibacterial agents are of clinical significance.

Expertly trained personnel will be pleased to discuss advanced clinical reports on a new therapeutic agent which may be described as a "mood stabilizer."

Booth 38. The Liebel-Flarsheim Company, Cincinnati. The Liebel-Flarsheim Company cordially invite you to visit the booth in which their latest electromedical-electrosurgical equipment will be exhibited. We ask particularly that you stop and see the L-F BasalMeter®, the first automatic, self-calculating metabolism unit ever offered. Capable representatives will be on hand at all times.

Booth 39. Lederle Laboratories Division, American Cyanamid Company, Pearl River, N. Y. You are cordially invited to visit the Lederle booth where our medical representatives will be in attendance to provide the latest information and literature available on our line. Featured will be Achromycin®, Achromycin V®, Kynex® and many other of our dependable quality products.

Booth 40. Geigy Pharmaceuticals, New York. The Geigy exhibit will feature Preludin® — the new chemically different appetite suppressant noted for its absence of side actions. Also on display will be Butazolidin®—potent nonhormonal antiarthritic; new Sterosan® Hydrocortisone Ointment — anti-inflammatory, bacteriostat and fungistat, and other well known Geigy products.

Booth 41. South Jersey Surgical Supply Co., Red Bank. Make booth 41 your headquarters. You are assured of a sincere welcome and an attention-arousing exhibit of useful surgical and medical appliances.

Booth 42. White Laboratories, Inc., Kenilworth. Stimulate appetite—improve muscle tone—speed convalescence through a more efficient utilization of protein. "Correct proportion of amino acids to each other in the diet is more important than total protein intake." White's L-lysine preparations—Lactofort®, Cerofort Tablets®, Cerofort Elixir® and Cerofort Drops®—raise milk, cereal and vegetable proteins to high values.

Booth 43. Desitin Chemical Co., Providence, R. I. Desitin® Ointment: the pioneer in external cod liver oil therapy. Indications: diaper rash, slow healing wounds, burns of all degrees, lacerations, hemorrhoids and fissures.

Desitin® Powder: a unique, dainty medicinal powder saturated with cod liver oil.

Desitin® Hemorrhoidal Suppositories with Cod Liver Oil: coats ano-rectal area with soothing, lubricating cod liver oil, gives prompt relief of pain, allays itching.

Desitin® Lotion: the original cod liver oil lotion, soothing, protective, mildly astringent and healing, in non-specific dermatitis, pruritis, poison ivy, *et cetera*.

Rectal Desitin® Ointment: A unique formula, providing rapid and effective relief in simple hemorrhoids, pruritus ani, fissures, *et cetera*. Does not contain narcotics, local anesthetics, styptics to mask any serious symptoms.

Booth 44. Walker-Gordon Laboratory Company, Plainsboro. You are invited to taste-test Walker-Gordon Certified milks at booth 44. You will find there the new Certified Lo-Sodium® Milk, which has been especially processed to reduce its sodium content from around 500 to less than 50 milligrams per quart. Walker-Gordon Acidophilus Milk, Certified Pasteurized Milk and Certified Skimmed Milk will also be available.

The Walker-Gordon Laboratory Company's Certified Milk Farm in Plainsboro, is the world's largest farm producing Certified Milk. It includes over 2400 acres of farm land and 2690 cows and growing heifers.

It is the home of the famous Rotolactor, the purpose of which is to make possible the production of the highest quality milk.

Walker-Gordon Certified Milk is distributed in the metropolitan area of New York and Philadelphia and in the State of New Jersey by many leading milk dealers.

Booth 45. The Sanabalm Company, Philadelphia. Sanabalm® Powder is an absorbent, healing, soothing, and protective medication. It has been proved clinically dependable for over 30 years for effective relief in the treatment of eczemas, intertigo, diaper rash, hyperhidrosis, bromidrosis, athlete's foot, bed sores, and other skin irritations.

Sanabalm® is non-sensitizing, non-irritating, and has an unusually fine texture. It absorbs moisture, promotes healing, helps reduce unpleasant odors, and provides a soothing cushion of comfort for irritated areas. The medicinal influence of Sanabalm® is long lasting because it adheres tenaciously to the skin. A clinical supply of Sanabalm® will be gladly furnished on request—with the compliments of the Sanabalm Company.

Booth 46. 7-Up Developers Association of New Jersey, Laurel Springs. You are cordially invited to "fresh-up" at the 7-Up booth. We have displayed the ingredients of 7-Up for your examination in order that you may have complete confidence in this refreshing beverage.

"Nothing does it like 7-Up."

Booth 47. Eaton Laboratories, Norwich, N. Y. For prompt results in urinary tract infections. Furadantin® is now available in the form of tablets and as Furadantin® Oral Suspension. Within 30 minutes after ingestion of this drug, the urine becomes strongly antibacterial.

It is effective in persistent or recurrent urinary tract infections of children where failure to treat promptly and adequately may produce serious sequelae which can shadow and shorten the patient's life.

For painless therapy of urethritis, Furacin® Urethral Suppositories are indicated. They relieve pain and burning rapidly, eradicate most bacteria common to urethral infections, cling to urethra for prolonged antibacterial effect, are easy for patient to insert at home, safe and non-irritating.

Booth 48. Bristol-Myers Products Division, New York. Bufferin®, the better-tolerated antacid-analgesic for long-term salicylate therapy, will be featured by Bristol-Myers. Also, Ammens® Medicated Powder, a highly efficacious dispersion of talc in cornstarch; Minit-Rub®, a greaseless-stainless rubefacient; and new Theradan®, for long-lasting relief of seborrhea of the scalp.

Booth 49. Dalzo, Inc., Hackensack. Dalzo, Inc. will have on display a complete line of products used in the treatment of vascular disease. Included will be the non-allergy flexible adhesive bardage Lestreflex, also the Nulast bandage made by the world-famous manufacturers of O. N. T. Thread, Coats & Clark. This bandage has natural rubber threads yet can withstand repeated hospital washings and sterilizing. We claim that when applied it will not SLIP. There will also be on display several types of medicated bandages that are used in the treatment of leg ulcers.

Booth 50. Wyeth Laboratories, Philadelphia. Wyeth will feature: Injection Phenergan® Hydrochloride (promethazine hydrochloride, Wyeth), for better preanesthetic sedation. Relieves apprehension, produces light sleep. Reduces postoperative nausea and vomiting. Of value for the control of any allergic reactions.

Pen. Vee. Oral® (Penicillin V, Wyeth) the oral penicillin with injectable performance, is an acid-stable penicillin that resists destruction by acid in the stomach. Absorption from the duodenum is maximal, therefore, high blood levels are assured. For treatment of infections caused by penicillin-sensitive organisms.

Equanil® (Meprobamate'* Wyeth) unique anti-anxiety factor with marked muscle-relaxing properties, for treatment of anxious and tense patients seen in everyday practice.

*Licensed under U. S. Patent No. 2,724,720.

Booth 51. Organon, Inc., Orange. Physicians are cordially invited to visit the Organon booth where well-known specialties will be presented. Among these will be: Cortrophin®-Zinc, the long-acting, aqueous ACTH; Wigraine®, the rapid-acting migraine therapy; Vistabolic®, the new gerontotherapeutic aid; Trevidal®, the protective, balanced, antacid; Pernaemon®, the painless liver injection; Nugestoral®, for the abortion-prone patient; and Liquaemin®, America's first and purest heparin. Samples and literature will be available and Organon representatives will be happy to discuss these advances in therapy with all interested physicians.

Booth 52. Maltbie Laboratories Division, Wallace & Tiernan, Inc., Belleville. You are cordially invited to visit the Maltbie booth to discuss our products with our representatives. Featured items will be Desenex®, the safest and most effective fungicide; Cholan V®, for maximal hydrocholeresis with effective spasmolysis; and Bifran®, for control of obesity and associated biliary disturbance.

Booth 53. Cameron Surgical Specialty Company, Chicago. Cameron Company has something sensational this year. An all stainless steel electro-surgical unit for office or hospital. Half the size, half the weight and half the price you think.

Also you will see the *only* absolutely safe headlite and rheostat for work in the presence of explosive vapors.

Booth 54. The Wm. S. Merrell Company, Cincinnati. Merrell representatives will discuss Meratran®, a new and unique antidepressant that works subtly and smoothly through its action on the subcortical area of the brain.

Please step at our booth, they will be happy to talk with you.

Booth 55. The Baker Laboratories, Inc., Cleveland. You are invited to visit our booth where Baker's Modified Milk and Varamel®, two successful products for infant feeding, are on display.

Baker representatives will be glad to discuss with you the special features of Baker Milk prod-

ucts which promote better tolerance, less colic, better gain and improved tissue turgor for bottle-fed infants.

Booth 56. Baby Service, Inc., Newark. Baby Service will be on hand with the famous red roses for the wives and a complete explanation of diaper service for both homes and hospitals. A cordial welcome will be extended to all who stop at the Baby Service booth.

Booth 57. C. B. Fleet Company, Inc., Lynchburg, Va. During the past fifty years Phospho-Soda® (Fleet) has been a symbol of elegance in sodium phosphate medication. Fleet Enema Disposable Unit—an enema solution of Phospho-Soda® (Fleet) — is a worthy companion product. The single-use unit simplifies and assures satisfying preparation for proctoscopy and as a routine enema it is a boon to the hospitalized patient.

Booth 58. Baby Development Clinic, Chicago. Invites you to see, hear the story of TMTD® (new germicide developed by Lever Brothers); to sample Lifebuoy with TMTD®. Learn why Evenflo Nipples with Patented Air Valves enable babies to nurse in comfort as at the breast. See other new Evenflo feeding products. Become acquainted with The Book House, a reading plan for parents and children from infancy to high school.

Booth 59. Winthrop Laboratories, New York. Levophed® Bitartrate, the most powerful pressor antidote for shock due to myocardial infarction, surgical and nonsurgical trauma, hemorrhage and other causes. Levophed® is noted for its prompt, predictable, reliable and easily controlled action. Administer diluted in 5 per cent dextrose or dextrose in saline solution.

Isuprel®: efficient and convenient bronchodilator, tablets for sublingual use, solution for inhalation.

Booth 60. Doho Chemical Corp., New York. Doho Chemical Corp. is pleased to exhibit:

Auralgan®, ear medication in otitis media and removal of cerumen;

Otosmosan®, effective, non-toxic fungicidal and bactericidal (gram negative-gram positive) in the suppurative and aural dermatomycotic ears;

Rhinalgan®, nasal decongestant free from systemic or circulatory effect and equally safe to use on infants as well as the aged.

New Larylgan®, soothing throat spray and gargle for infectious and noninfectious sore throat involvements.

Rectalgan®, liquid topical anesthesia, for relief of pain and discomfiture in hemorrhoids, pruritus and perineal suturing.

Dermoplast®, aerosol freon propellent spray for fast relief of surface pain, itching, burns and abrasions. Also obstetrical and gynecologic use.

Booth 61. U. S. Vitamin Corporation, New York. Exhibit features C.V.P., an exclusive water-soluble citrus bioflavonoid compound with ascorbic acid—for restoring and maintaining capillary integrity. Corrects or minimizes capillary abnormality and bleeding associated with diabetes, hypertension, epistaxis, purpura, gingivitis and certain forms of gastro-intestinal, rectal and vaginal bleeding. Effective therapy in habitual and threatened abortion.

Professional samples and literature distributed also on our complete line of nutritional and pharmaceutical specialties.

Booth 62. Schering Corporation, Bloomfield. Members of The Medical Society of New Jersey and their guests are cordially invited to visit the Schering exhibit where new therapeutic developments will be featured.

Schering representatives will be present to welcome you and to discuss with you these products of our manufacture.

Booth 63. Ross Laboratories, Columbus, Ohio. Current concepts in infant feeding, stressing the critical aspects of preventive care. Your Similac® representative will be happy to discuss the role of physiologic feeding in providing good growth, sound development, and optimum clinical benefits. Copies of the latest Ross Pediatric Research Conference Reports are available.

Booth 64. Robert H. Wuensch Company, East Orange. The Robert H. Wuensch Company of East Orange is featuring the Murray Space Shoe at the convention exhibit. Be sure to stop by! You will learn the fascinating details of this revolutionary shoe and see how they are molded to the plaster cast of the wearer's feet. This is the famous molded shoe to which *Life Magazine* devoted four pages in a recent issue. It is the *original,* genuine Space shoe created by Alan E. Murray of New York and Wuensch's of East Orange is the *only retail store in New Jersey authorized to take casts and service Murray Space Shoes.*

Booth 65. Medco Products Co., Tulsa, Okla. Medco presents the 3-Way Medco-Sonlator; offering electrical muscle stimulation and ultrasound simultaneously through a single three way applicator. This unique modality makes it possible to locate and treat trigger points. It affords an effective therapeutic weapon for the treatment of strains, sprains and dislocations. It promotes the resolution of exudates through muscle stimulation; increases blood and lymph flow. The Medco-Sonlator is a useful adjunct in producing relief of symptoms such as pain, soreness and tenderness associated with nonspecific types of bursitis, periarthritis, fibrositis, tenosynovitis, myofascitis, arthritis and neuritis.

Booth 66. The S. E. Massengill Company, Bristol, Tenn. The S. E. Massengill Company extends its wishes for a most successful meeting and invites the convention to visit its booth and discuss Massengill Pharmaceutical products. The S. E. Massengill Company will feature Adrenosem® Salicylate (the unique systemic hemostat), Homagenets® (the only homogenized vitamins in a solid form), Salcort® (a safe, effective anti-arthritic) and Massengill Powder.

Booth 67. Burroughs Wellcome & Co. (U.S.A.) Inc., Tuckahoe, N. Y. New Products:—The extensive research facilities of "B.W. & Co.," both here and in other countries, are directed to the development of improved therapeutic agents and technics.

Through such research "B. W. & Co." has made notable advances related to leukemia, malaria, diabetes, and diseases of the autonomic nervous system: and to antibiotic, muscle-relaxant, antihistaminic, and antinauseant drugs.

An informed staff at our booth will welcome the opportunity to discuss our products and latest developments with you.

Booth 68. Abbott Laboratories, North Chicago, Ill. The new sedative, tranquilizer and antihypertensive, Nembu-Serpin® Filmtabs will be among new products exhibited by Abbott Laboratories. Also shown will be the new non-barbiturate hypnotic, Placidyl®; Desbutal®; Erythrocin® Filmtabs; Iberol® Filmtabs; Optilets® Filmtabs; Vi-Daylin®; Selsun®; Pentothal® Sodium; and Abbott's complete line of intravenous solutions and equipment.

Booth 69. The Upjohn Company, Kalamazoo. Members of the medical profession are invited to visit the Upjohn booth where members of The Upjohn Company professional detail staff are prepared to discuss subjects of mutual interest.

Booth 70. Pfizer Laboratories, Brooklyn. The Pfizer exhibit spotlights its recent and original therapeutic concepts represented by Sigmamycin® (brand of oleandomycin), a combination of Matromycin® and Tetracyn®; and the newest advance in topical corticosteroid therapy, Magnacort® and Neo-Magnacort®, the first water soluble corticoid. Also Moderil®—Pfizer's new alkaloid of rauwolfia. Ataraxoid®, the first and only ataraxic-corticoid, as well as Bonamine®, and Sterane®.

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The Medical Society of New Jersey
Annual Reports to the House of Delegates

President

(Reference Committee "A")

Lewis C. Fritts, M.D., Somerville

There is a note of termination about the preparation of a presidential report. It brings home to me very vividly the realization that my term of office will soon be over, that my opportunities for service as the President of The Medical Society of New Jersey will soon be at an end. I recognize that fact, and I prepare to relinquish the office with a mixture of satisfaction and of regret.

It has been a source of satisfaction to me to act as the spokesman and representative of the Society for the year now closing. I have been made to realize—as no one not active in its affairs can realize—how extensive is the scope and how exacting are the interests of The Medical Society of New Jersey. I have been intimately a part of operations that left no sphere of proper concern unregarded. In the course of the year, through the work of the Board of Trustees and the more than forty active committees of the Medical Society, I have helped to further the aims and purposes of our organization in dealings that involved the members themselves, the Woman's Auxiliary, our component societies, other state medical organizations, the American Medical Association in all its many branches, other professional and ancillary groups, state and national legislatures and legislators, agencies and departments of governments, and representatives of organizations and groups dedicated to academic, service, and social aims which impinge upon areas of medical interest.

The concerns of this Society are presently as comprehensive and complex as are the aspects of everyday living. Newman has observed that an educated man should know something about everything, and everything about something. It is certainly true of us today. If we are to maintain our status as members of a distinguished and unfettered profession, if we are to do our job, we must know everything—or as much as we can—about that significant something which is modern Medicine. Likewise, we must know something about the everything which constitutes the complexus of living in the restless, changing social climate of today.

In The Medical Society of New Jersey we are striving together to accomplish a formidable and challenging work. To carry it on without close-knit and vigorous organization is utterly impossible. That is a point which I emphasized as I took office. That is a point which I wish to reemphasize as I retire to the ranks. Whether in a position of prominence or of anonymity, each of us as a member of The Medical Society of New Jersey—as a member of the profession of medicine—must join his strength and unite his efforts with those of all his colleagues, in order that Medicine and the people may be well and satisfactorily served. It is a hard and complicated task that confronts us, but hard and complicated tasks afford the sweetest savor of satisfaction when they are brought to a successful conclusion.

In the surging, changing struggle of life today it is impossible to restrict either the challenges or the solutions to limits of time and circumstance. As life and change are continuous, so must be our efforts. This year we have worked hard at our tasks, and I feel we have moved always toward fulfillment. What we have done has been possible because of the generous and consistent cooperation of all who have joined in the effort. When more are working together our achievement will be quickened and enlarged. That is why I should like to reiterate a sentiment which I uttered in my inaugural address:

> In The Medical Society of New Jersey today we need men and women of unselfish dedication and action. We need men and

women of vision and industry, to take their places on our committees and to do their best to do their jobs. We need men and women who in their daily practice will deal with their patients not only so efficiently but so intelligently and compassionately that they will make each patient a stalwart admirer of the entire profession. We need men and women of such character and worth that each will be an influence for better public relations with all his patients. In short, we need men and women who love Medicine and their fellowmen, and who serve what they love unselfishly.

We have many such now. It has been my pleasure and privilege to work with them as they rendered service to the Society as officers, members of the Board of Trustees, and chairmen and members of our many committees.

In the name of the Society, I thank all those who have through this year labored in its behalf. I hope that through the years to come they will continue to serve with distinction, and that others will ally themselves with them. By this means, and only by this means, will The Medical Society of New Jersey be able to meet and overcome the formidable challenges that confront it.

Secretary

(Reference Committee "A")

MARCUS H. GREIFINGER, M.D., Newark

The office of the Secretary continued to be active. Routine correspondence has been promptly answered and questionnaires from various sources completed and returned.

The Secretary attended the Annual Meeting of the American Medical Association, as well as meetings of the Board of Trustees of The Medical Society of New Jersey and of the several committees of which he is chairman, member, or advisor.

MEMBERSHIP

(As of December 31, 1956)

Active-Paid	5,563
Exempt	264
Total Active	5,827
Associate	270
New and reinstated members	264
Members deceased	62
Transfers in state	29
Resignation and transfers out-of-state	25
State Emeritus Members	112
State Honorary Members	4
Members dropped for non-payment of dues	97
A.M.A. Members	5,379

A.M.A. MEMBERSHIP

New Jersey membership in the A.M.A. is growing; 5,205 in 1954, 5,300 in 1955, and 5,379 in 1956. On the basis of one delegate per 1,000 members or fraction thereof, New Jersey has six delegates to the A.M.A.

MEMBERSHIP DIRECTORY

Work is progressing toward the publication of the 3rd edition of the Membership Directory in the fall. Current directory listings have been mailed to the membership for correction and return. In addition, listings of new and reinstated members not included in the 1955 issue have been prepared and submitted for correction. To date a total of 6,587 listings have been mailed; 4,654, or 71 per cent have been returned. As new and reinstated members are being reported for 1957, listings are prepared promptly and mailed so that the new issue will be as complete as possible.

Members not paid-up by June 1 will not be included in the new directory. For those who do not return their listings by that date, the listings will remain the same as in the 1955 edition.

Five thousand, eight hundred and sixty-three copies of the 1955 Membership Directory were distributed without charge to active members. Seven hundred and sixty-one copies were sold, and 376 copies are on hand.

Treasurer

(Reference Committee "B")

Jesse McCall, M.D., Newton

As the fiscal year does not close until May 31, 1957, the annual report of the Treasurer cannot be submitted at this time. An interim report will be presented to the House of Delegates on April 27, 1957 covering the accounts to that date.

Board of Trustees

(Reference Committee "A")

C. Byron Blaisdell, M.D., Chairman, Asbury Park

The report of the Board of Trustees can only highlight the Board's actions of the year —most of which have been reported in The Journal. This year has made heavier than usual demands upon the time of the Trustees. Six meetings have already been held for which there are 145 pages of minutes, and two more meetings before the annual meeting are scheduled.

I wish to record my gratitude to all the Board members. They have served loyally and diligently in the interests of the Society; and I commend the dependable and orderly work of the numerous committees. Their generous endeavors greatly facilitated the conduct of the Society's business.

COUNSEL

Following interviews with several attorneys-at-law by the chairman and the President, at which painstaking consideration was given to all factors of preparation, experience, and availability—all candidates being qualified and personable, and it was a difficult decision—the Board engaged Robert M. Backes of Trenton as Counsel for The Medical Society of New Jersey for the current year. Mr. Backes has been of great assistance to the Board, the Judicial Council, and to the Society in general on many occasions when his opinions have been sought. One of his duties is to serve as Parliamentarian at the annual meeting, and he will provide this service at this year's convention.

MIDDLESEX COUNTY APPLICANT FOR MEMBERSHIP

Much time was given to the several requests of the Middlesex County Medical Society for an opinion on the eligibility of an applicant for membership. A review of the applicant's record disclosed that he has a full license to practice medicine and surgery as a doctor of osteopathy from the State Board of Medical Examiners and that he has, subsequently, in consequence of one year's attendance in medical school in Italy, acquired an M.D. degree which the State Board does not recognize. The Board of Trustees affirmed and then reaffirmed an early action, which stated:

> that the applicant is ineligible for membership—in a county medical society, the State Society, and the A.M.A.—on the basis that he is licensed to practice as a Doctor of Osteopathy, that his M.D. degree is not recognized inasmuch as it was obtained without the necessary four years' attendance at a recognized school of medicine, and that he is ineligible for examination to receive a license as an M.D.

Following this the Board was requested to provide a legal opinion on the matter. The Board ruled that the responsibility for passing upon the eligibility of candidates for membership in this Society or its component societies, under the Charter of 1864, rests with the Society. It does not belong, nor should it be delegated, to the Society's legal counsel. There-

fore, the Board found itself constrained to deny the request that it offer a specific legal opinion concerning the question of the applicant's eligibility. It was pointed out that as a matter of regular procedure, all actions of the Board are taken with the awareness and advice of counsel.

HISTORIAN-ARCHIVIST

Recognizing that the Society will celebrate the bicentennial of its founding nine years from now, in 1966, that an historical resumé probably will be desired at that time, and that it might be advantageous to begin preparing the historical materials to be utilized, the Board created the post of historian-archivist for the Society. Dr. Fred B. Rogers of Trenton was appointed to the post. An appropriation to cover the expenses of collecting and preparing historical materials has been requested of the Finance and Budget Committee.

EUTHANASIA

In response to many requests for a statement on a news release in consequence of the fact that a number of New Jersey physicians had signed a petition, addressed to the Legislature, urging that euthanasia be legalized, the following statement was approved by the Board and released to all newspapers in the state on January 21, 1957:

> The attention of the Board of Trustees of The Medical Society of New Jersey has been called to a recent news item which reported that 166 New Jersey physicians had signed a petition calling on the State Legislature to legalize euthanasia. The Board of Trustees wishes to point out that as private citizens those physicians have the right to their own opinions and actions, but those opinions are not to be construed as reflecting the official and accepted position of organized medicine regarding euthanasia. The practice of euthanasia has been and continues to be in conflict with accepted principles of morality and sound medical practice.

PRINCIPLES OF MEDICAL ETHICS

The Judicial Council expressed dissatisfaction with and opposition to the proposed revision of the Principles as written and urged that the New Jersey Delegates to the American Medical Association Clinical Session oppose its adoption. It was the consensus of the Trustees and Delegates that the arguments offered by the Judicial Council in opposition to the proposed revision were well founded and constructive. The Board instructed the New Jersey delegates to oppose the adoption of the proposed revision and to use the arguments of the Judicial Council as a guide. The revision was not adopted, but further revision is to be considered at the 1957 A.M.A. meeting in New York.

Several items are still under consideration by the Board and its special committees. We will reflect our progress on them in our supplemental report.

PERMANENT CAPITAL FUND — MEDICAL STUDENT LOAN FUND

(Reference Committee "B")

The 1956 House of Delegates approved recommendations to establish a Medical Student Loan Fund of The Medical Society of New Jersey, and authorized that funds up to $3,000 be taken temporarily from Surplus for the first year. It was the original proposal of the committee that monies for the fund be transferred from the Permanent Capital Fund. However, the proposal was not made in time to adhere to the regulations in the By-Laws.

Chapter IX, Section 1 (b) of the By-Laws requires that the principal of the Permanent Capital Fund may be expended only when so ordered by a two-thirds vote of the House of Delegates, such expenditure having previously been approved by the Board of Trustees, and notice of such approval sent to the component societies at least one month in advance of the meeting of the House at which action is to be taken.

The amount in the Permanent Capital Fund is $15,065.25.

In compliance with the regulations of the By-Laws, the Board of Trustees approved—at its meeting on January 13, 1957—using the funds in the Permanent Capital Fund for the purposes of the Medical Student Loan Fund; and all component societies were so notified by letter on January 25, 1957.

Recommendation:

> That the 1957 House of Delegates approve using the funds now in the Permanent Capital Fund for the purposes of the Medical Student Loan Fund of The Medical Society of New Jersey.

MEDICAL SERVICE ADMINISTRATION

(Reference Committee "B")

The Board was informed that the portion of salary and such expenses incurred by Medical Service Administration in the work connected with the Medicare program will be paid by the subcontractor, Hospital Service Plan. However, Medical Service Administration was in the same situation as in other years—in that its income from the Newark City Plan was insufficient to meet operating expenses—and a subsidy from the Medical Society for the operational deficit would again be necessary.

As provided in the current budget, the Board of Trustees authorized another grant of $5,000 to the Medical Service Administration for operating expenses in 1957.

AMERICAN MEDICAL EDUCATION FOUNDATION

(Reference Committee "B")

The appropriation of $25,000 to the American Medical Education Foundation, while not stipulated as a calendar or fiscal contribution, was made to the A.M.E.F. at the A.M.A. Clinical Session in Seattle, and has been recorded as a 1956 contribution. This was in accordance with the way previous contributions had been made—before the end of the calendar year.

MEDICARE

(Reference Committee "C")

Public Law 569, 84th Congress, was signed by the President on June 7, 1956, thereby authorizing the federal government to assume responsibility for the care of dependents of members of the uniformed services. A conference was called by the A.M.A. last summer with representatives of state societies and government to review the status of the law and the regulations to implement it. The Board last September approved in principle the proposal made by the government for the medical care of dependents of military personnel, and participation of the Medical Society in the implementation of the program; designated Medical Service Administration as the Society's fiscal agent in the program; and appointed a special committee to work on a schedule of benefits and such other items as may properly come within the program. The committee consisted of Drs. McCall, Sica, Bowers, and Ware, with Dr. Borsher as advisor. The committee also served as the Society's negotiating agent.

By the end of October a satisfactory schedule of benefits, applicable to the area of the State of New Jersey, had been negotiated. It will be found that in the final schedule, there will be no example of a fee less than a corresponding one in the current M.S.P. Schedule. In a great number of items, the Medicare schedule will run at a considerably higher level. It took considerably longer to negotiate the contract inasmuch as the government, after an audit, declared that in its opinion Medical Service Administration was not equipped nor had it the facilities to perform the functions necessary to administer the provisions under the contract. The Board was informed that M.S.A. is permitted to receive money from any government source and pay any fees — medical, hospital, dental, etc., that Hospital Service Plan could not under its enabling act be the direct contractor as fiscal agent, but could be a subcontractor, and that M.S.A. was the only logical agency to serve as fiscal administrator for the Society and would probably have to serve in the same capacity for the hospitals. On the basis of this, the Board reaffirmed its designation of M.S.A. as the Society's fiscal agent in the program, and authorized M.S.A. to enter into a subcontract with H.S.P. Subsequently, the government approved the contract which named M.S.A. as the Society's fiscal agent and H.S.P. as the subcontractor. It was noted by the Board at a later meeting that the New Jersey Hospital Association had subcontracted the Medicare Program in Hospitals directly to Blue Cross without utilizing the services available through M.S.A.

With the completion of its work on the contract and schedule of benefits, the Board discharged the Special Committee on Medicare with thanks for having fulfilled its duty so magnificently. The special committee was renamed the Special Committee on Medicare Disputed Bills, which committee is called for in the contract. We know the members will do the same excellent job on this phase of the program.

MEDICAL-SURGICAL PLAN CONTRACT CHANGES

(Reference Committee "C")

The resolution adopted by the 1956 House of Delegates — which called upon Medical-Surgical Plan of New Jersey to submit any contemplated basic changes in its contract to the proper groups of the Society in accordance with a specified schedule—was referred by the Board of Trustees to the Medical-Surgical

Plan Board of Trustees for comment and response.

The Board was informed by Medical-Surgical Plan that M.S.P. has been carrying out the procedures suggested in the resolution. Medical-Surgical Plan is a separate corporation answerable to the Commissioner of Banking and Insurance, and it would not set well with the Department if it could be established that Medical-Surgical Plan procedures are dictated by another corporation, even the Medical Society.

The Board of Trustees approved the response from Medical-Surgical Plan, and an explanatory letter with notice of approval was sent to each of the county societies concerned with the original resolution.

MEDICAL FEES IN MEDICAL-SURGICAL PLAN

(Reference Committee "C")

The 1956 House of Delegates approved in principle a resolution that hospitalized medical cases be put on a fixed fee basis, and approved the recommendation of the reference committee that the Boards of Trustees of the Medical Society and Medical-Surgical Plan take the resolution under advisement. The resolution was referred by the Board to Medical-Surgical Plan for comment and response.

The response from Medical-Surgical Plan stated:

> The Plan has been in accord with the purpose of such a resolution for years, and has had many conferences in the past with various professional groups, but has been unable as yet to develop a feasible method of "package fee" approach for medical cases. The conferences did result in improved methods of payment for medical services which were feasible and have subsequently been adopted by some other Blue Shield Plans. The American College of Physicians (New Jersey chapter) has not been represented at these past conferences, though invited by the Plan to attend.

Judicial Council

(Reference Committee "A")

D. F. Featherston, M.D., Chairman, Asbury Park

Apart from its work as an appellate tribunal considering matters originally dealt with by county judicial committees, the Judicial Council has the responsibility of supervising, directing, and keeping records of all complaints dealt with by county judicial committees as matters of original jurisdiction. To accomplish this, the Council, through the cooperation of county judicial committees, receives reports of all cases accepted for adjudication by county judicial committees, and of the dispositions made of them.

From the official files of the Judicial Council, we present the following resumé of the operations of the Judicial Council and of county judicial committees for the year now ending February 28, 1957:

By the Judicial Council:

Appeal Hearings Requested	11
Appeal Hearings Held	6
Opinions Rendered	3

1) Opinion concerning the ethics of an individual physician's agreeing to be a subject for a profile

2) Opinon concerning the ethics of a doctor of medicine's accepting employment in an osteopathic hospital and accepting appointments to staff of an osteopathic hospital

3) Opinon concerning the revision of the code of ethics of the American Medical Association

(N.B.—For the information of the membership, these three opinions are presented in full as an appendix to this report.)

By County Judicial Committees:

Complaints reported as disposed of	62
Complaints still pending	25

In the course of the 190th Annual Meeting of The Medical Society of New Jersey, the House of Delegates adopted extensive revisions of the By-Laws of The Medical Society of New Jersey dealing with the Judicial Council. In consequence of the adoption of the new By-Laws, the Judicial Council, in October of 1956, exercising the regulatory powers granted under the By-Laws, prepared and distributed a set of "Regulations for the Processing of Grievances and Complaints against Members

of The Medical Society of New Jersey and of Component County Societies." Copies of these Regulations were supplied to chairmen of county judicial committees and to the secretaries of all county medical societies. The foreword to the Regulations declares:

"The Judicial Council of The Medical Society of New Jersey and the judicial committees of component county medical societies constitute a judicial mechanism established as the result of action taken by the House of Delegates of The Medical Society of New Jersey in May, 1950.

"The judicial mechanism is intended to improve public and intra society relations by making available a means whereby differences and disagreements can be brought informally to a settlement that is fair to the interests of all parties.

"Original jurisdiction concerning complaints rests with the judicial committee or committees of the component county medical society or societies in which the doctor or doctors involved hold membership. Appeals from the findings of county judicial committees may be taken to the Judicial Council of The Medical Society of New Jersey. Beyond the Judicial Council of The Medical Society of New Jersey appeals may be taken to the Judicial Council of the American Medical Association. The House of Delegates of The Medical Society of New Jersey is the legislative body, and the Board of Trustees and the officers constitute the executive body of the Society. The Judicial Council is the judicial body of the Society, with plenary responsibility for the supervision and maintenance of the judicial mechanism.

"The mechanism is not intended either to coerce or to exculpate member-physicians. It is intended to demonstrate that within the family, as it were, Medicine can equitably and amicably settle its own problems, and thus discourage recourse to civil courts.

"Indeed, only when all principals to a complaint agree to submit the matter of the complaint to our judicial mechanism, and give assurance that no court action is pending or contemplated, should the matter be accepted for processing."

Improvement in the statewide operation of the judicial mechanism has continued. Unfortunately, there are still a few county judicial committees that have been lax in the fulfillment of their responsibilities. The Judicial Council again takes occasion to urge that county judicial committees which have not extended full cooperation immediately do so, in the interest of the efficiency of the entire judicial mechanism, the satisfaction of the public by means of an instrumentality controlled by the Society, and of the protection of our members. As we said in last year's report, "It is a disservice to members if county judicial committees do not function promptly and dependably. Inaction or inefficiency on the part of a county judicial committee withholds from members complained against by the public the service and advantage of a hearing before an officially approved body of professional peers, whose judgment of the matters of the complaint are based not only upon adequate knowledge but upon a familiarity with all phases of the circumstances involved. A clear-cut decision rendered by a county judicial committee, which is prepared to demonstrate the impartial accuracy of its findings, liberates deserving members from the shadows of charges which otherwise might indefinitely linger, to the lasting dissatisfaction of all parties involved."

I cannot close this report without citing for the appreciation of the House of Delegates the splendid services rendered by my colleagues of the Judicial Council: Dr. Ralph M. L. Buchanan, from the First District; Dr. Joseph M. Keating, from the Second District; Dr. Charles M. Calvin, from the Third District; and Dr. Isaac N. Patterson, from the Fifth District.

The Judicial Council meets monthly throughout the year except for the summer months of July and August. Its agenda is always extensive. Its entire membership is regularly present. Inasmuch as attendance at these meetings necessitates a sacrifice of one Sunday a month, I think the constancy and conscientiousness of the Councilors well deserve special commendation.

Opinon of The Judicial Council of The Medical Society of New Jersey Concerning the Ethics of an Individual Physician's Agreeing To Be a Subject for a Profile

(Opinion officially adopted March 18, 1956)

The Judicial Council of The Medical Society of New Jersey has been asked to render an opinion concerning the ethics of an individual physician's agreeing to be the subject of a "practice profile" in which one physician would be selected for a complete profile "exclusive of his social and personal life. In detail would be described his professional life as well as his office routines and administration. The physician chosen would be 'someone who is representative of hundreds of others like him, personable, well thought of in the community, successful though not unusually so.' "

It was the opinion of the Judicial Council that there is nothing wrong with the proposals contained in the requests. It pointed out, however, that the canon which must constantly guide all physicians in this regard is Chapter I, Section 4 of the "Principles of Medical Ethics of the American Medical Association," which reads:

> Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician. Among unethical practices are included the not always obvious devices of furnishing or inspiring newspapers or magazine comments concerning cases in which the physician or group or institution has been, or is, concerned. Self-laudations defy the traditions and lower the moral standard of the medical profession; they are an infraction of good taste and are disapproved.
>
> The most worthy and effective advertisement possible, even for a young physician, especially among his brother physicians, is the establishment of a well merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of simple professional cards is approved in some localities but is disapproved in others. Disregard of local customs and offenses against recognized ideals are unethical.

It is the opinion of the Council that each case must be separately considered in the light of the section quoted. Final decision rests with the county medical society which must decide whether or not the individual physician is acting within the scope laid down by the section, and in so doing is in no wise indulging in self-exploitation.

Opinon of The Judicial Council of The Medical Society of New Jersey Concerning the Ethics of a Doctor of Medicine's (1) Accepting Employment in an Osteopathic Hospital; (2) Accepting Appointments to Staff of an Osteopathic Hospital

(Opinion officially adopted December 20, 1956)

The Judicial Council was asked to render an opinion whether under any circumstances it would be ethical for a doctor of medicine to accept (1) employment in an osteopathic hospital, and (2) appointment to the staff of an osteopathic hospital.

The Judicial Council unanimously agreed that the answer to these questions can be found in Chapter II, Section 1 of the "Principles of Medical Ethics of the American Medical Association," which principles govern the conduct of the members of The Medical Society of New Jersey in their relations to each other and to the public: ". . . All voluntarily associated activities with cultists are unethical . . ." In support of this, the Judicial Council calls attention to that portion of the Report of the Judicial Council of the American Medical Association dealing with osteopathy, submitted to the House of Delegates at the 1955 A.M.A. Boston Clinical Meeting, as follows:

> For many years osteopathy has been designated as a cult by the American Medical Association. It is a practice that follows a dogma, tenet, or principle that is based on theories or beliefs of its promulgator to the exclusion of demonstrable, scientific experience. The "Principles of Medical Ethics of the Association" proscribe as unethical all voluntarily associated activities with cultists. It appears to the Judicial Council that the House of Delegates, by discharging the Committee to Study Relations Between Osteopathy and Medicine, has not changed its policy in regard to the relationship of members of the American Medical Association with osteopaths. Therefore, the Judicial Council reaffirms the statement in its 1952 annual report: "Thus, in the absence of a directive from the House of Delegates, and in the absence of any alternative statement from the osteopaths themselves that they no longer adhere to their original cult theories, the Judicial Council reasserts its opinion that all voluntary associations with osteopaths are unethical." Only the House of Delegates can alter this policy and, until the House is convinced that osteopathy is no longer a sectarian practice and so votes, it is incumbent on the members of the Association to observe existing policy.

In the light of the foregoing, the Judicial Council unanimously reaffirmed its opinion that association with osteopathic physicians as professional co-equals, in or out of hospitals, contravenes the "Principles of Medical Ethics of the American Medical Association" and is therefore unethical. In consequence, under no circumstances can it be condoned.

Opinon of The Judicial Council of The Medical Society of New Jersey Concerning the Revision of the Code of Ethics of The American Medical Association

(Opinion officially adopted November 4, 1956 and referred to the Board of Trustees)

The Judicial Council of The Medical Society of New Jersey, meeting on November 4, 1956, discussed the proposed revision of the Code of Ethics which will be presented to the House of Delegates of the American Medical Asso-

ciation at the clinical meeting in late November for final action.

The members of the Judicial Council were unanimous in the opinion that the proposed revision of the Code of Ethics is not an improvement on the old code; neither is it desirable nor workable from the point of view of interpretation and enforcement. This, we feel, is a most important consideration to us who carry the responsibility of dealing with matters and questions involving ethics and professional conduct.

The present principles are definite and binding. The proposed principles—undertaken to achieve simplification—have attained, instead, indefiniteness and ineffectuality. In other words they impress us as being as good as nothing.

It is of the nature of ethical principles that they necessarily embody fundamental moral considerations which must be deferred to and observed by *all* for the preservation of sound social order. They cannot be offered to individuals to observe or to disregard at choice. Such a procedure would nullify their usefulness and produce social anarchy. Nor can they admit of subjective evaluation as regards individual conformity. If each individual physician is to judge for himself concerning the adequacy or inadequacy with which he lives up to these ethical principles, then there is no possibility or use in organized medicine for judicial bodies of any kind. Each member will become a law unto himself and will be answerable only unto himself for the propriety or impropriety of his actions.

Ethical principles must be universally binding or they are impotent. They must have—and, in the natural order, they do have—the impact and the effect of law — the natural moral law. Yet the preamble of the revised code declares: "They (the principles) are not laws; rather they are standards by which a physician may determine the propriety of his own conduct." This, we contend, smacks of nonsense.

Section I undertakes vaguely to outline a physician's responsibility in the care of his patient, but makes no specific declaration as to what that responsibility entails.

Section II attempts to indicate a physician's duty in the development and use of his medical knowledge, but is entirely too unspecific to have any real meaning.

Section III is probably intended to control a physician's association with cults and cultists, but does not say so. Instead it speaks of dogmas and sects in a way that seems to savor of dictating the character of the religious convictions that a physician may as an individual entertain. This is a dangerously ambiguous and inadequate section, which, failing of its proper purpose, could produce much intense dissention.

Section IV achieves climatic absurdity by sanctimoniously calling upon "physicians to observe all laws, uphold the dignity and honor of the profession, and accept its self-imposed disciplines" after having denied in the preamble that any laws are binding or that any disciplines have been imposed. It also goes on to call upon physicians to "expose, without hesitation, illegal or unethical conduct of fellow-members," thus calling for an objective evaluation of ethical conduct though in the preamble it declares that the physician is the arbiter of "the propriety of his own conduct."

The statement in Section V, "He should not solicit patients," to be perfectly clear should indicate the methods by which patients should not be solicited and should specifically indicate the official stand on advertising.

Section VI is silent with reference to the exploitation of services of physicians for financial profit, and accepts as the sole criteria for the disposal of such services the freedom of exercise of the physician's medical judgment and skill, or the deterioration of the quality of medical care rendered. This section seems to us as especially deficient in view of the present furor arising out of the so-called corporate practice of medicine.

Section VII states that a physician "should limit the source of his professional income to medical services actually rendered by him to his patient." It does not indicate what is meant by professional income, and it fails to specify any activities that a physician may ethically engage in which do not actually consist of rendering medical service to a patient.

Section VIII deals with the matter of consultations, but, like so many of the other sections, remains a generalization, lacking clarity and definiteness.

The Judicial Council of The Medical Society of New Jersey does not oppose a constructive revision of the "Principles of Medical Ethics of the American Medical Association," provided that no basic ethical canon is disregarded or fundamental protection lost; but it is firmly of the conviction that such a revision should be consonant with the retention of the true character and the salutary effects of a sound and complete code. The revision presently being offered for adoption, in the opinion of the Judicial Council, is unsound and dangerous. Therefore the Judicial Council of The Medical Society of New Jersey

strongly recommends that the delegates to the American Medical Association from The Medical Society of New Jersey vigorously oppose its adoption.

Moreover, the Judicial Council recommends that our delegates to the American Medical Association spearhead a concerted effort to accomplish the defeat of this proposed revision by transmitting to the delegates of other states the official opinions and recommendations ultimately arrived at by The Medical Society of New Jersey.

Executive Officer

(Reference Committee "A")

RICHARD I. NEVIN, Trenton

Just as, through the magic of interest, an hour well-spent may pass in ten minutes, so an administrative year crowded with multitudinous activities may pass in little more than ten months. Of course, an early convention date may speed the year to its close—as this year it has—but the fact remains, at least for all of us who have been about the Society's business, that the year has moved with incredible swiftness.

It has been a busy year, not because we bustled to make it seem so but because the demands which our duties impose upon us made it impossible that it be otherwise. Shortly after the closing session of the House of Delegates the work of the new year gets under way: The Board of Trustees re-organizes; committees meet for the purpose of learning their official functions and of adopting programs for the year (we have some forty active committees); all interested groups and parties—within and without the profession—must be apprised of new policies and new programs emanating from the House of Delegates. Once committee programs are officially approved by the Board of Trustees, the work of the new year surges ahead.

Through the Executive Offices, with the direction and cooperation of the officers, we conduct official operations. All membership services are rendered; all committee meetings are arranged and covered; all correspondence is dealt with; all contacts are maintained — with agencies of organized medicine, with agencies of government, with paramedical and ancillary organizations, and with agencies of public service and interest; all questions are answered; all challenges are evaluated and met. Each day imposes its burdens of routine service; but also each day, almost without exception, introduces unanticipated problems that must be dealt with promptly and efficiently.

As an embellishment upon the work above described, your officers must find time and energy to fill official and social engagements which fall to them as the Society's spokesmen and representatives. I can give you an idea of what these commitments involve by reporting that since I wrote my preceding report I find that I have participated in 118 meetings or conferences and have filled twenty-three speaking engagements. All your other officers are called upon to face up to similar demands.

For this reason I wish to pay tribute to the members of the Board, and to all the officers and agents of the Society for their generous gift of time and of service. They show to us all just what high service imposes, and how it can be rendered.

I feel I can with confidence report that progress has continued in the Society's organization and in its functional operations. For example, the four subcommittees to the Welfare Committee have moved with expert sureness about their work. The Subcommittee on Legislation has continued to use with increasing satisfaction its orderly keyman system, and the adequacy of its operation is evident in the smoothness with which the Society's interests in proposed state legislation are safeguarded. The Subcommittee on Public Relations has not been content to carry on established programs merely, but it is adding to its scope and achievements by such new enterprises as the preparation of a code of cooperation with the press of New Jersey and the establishment of the Golden Merit Award for members who have been in practice for fifty years. Likewise, the Subcommittees on Public Health and Medical Practice have well and effectively addressed themselves to the detailed business proper to them, and by dint of painstaking study and effort have done a commendable job.

The thought may arise, "If so much is

done and so well done, why should not Medicine today be more secure and in high regard?" The answer is "Because there is more to do." That "more" which remains to be done is sufficiently demanding—especially in areas of social attitudes, economic agressions, and political pressures—to keep every single member consistently engaged. These are days to try the mettle of Medicine as a profession, and of physicians as individuals. We must stand and work together, within the framework of our Society's structure, to preserve the best that we have—for our fellow citizens and ourselves —and to resist the deleterious and unwholesome changes that our adversaries would thrust upon us. Medicine is confronted by a changing world. It remains for Medicine, by the best exercise of its capacities and its strengths, to work with unity of purpose and of action to control the extent of the changes that occur and to keep them within the limits of genuine advantage to the general good. That job will not be done in a day or a year or even a decade. Perhaps the Executive Officer will be able to supply progress reports later. He hopes that he will.

Nominations for Emeritus Membership

(Reference Committee on Resolutions and Memorials)

The following nominations for election to emeritus membership at the 1957 Annual Meeting have been received from the county medical societies. In conformity with the provisions of Article VI, Section 7, of the Constitution, governing Emeritus Membership, all nominees have been members in good standing of a component county society for at least twenty years, and by reason of age or infirmity, have retired from the active practice of medicine.

ATLANTIC COUNTY

John Pennington, M.D., Ventnor; age 65.

BERGEN COUNTY

William K. Harryman, M.D., Hackensack; age 61.
Herman J. Horowitz, M.D., Ridgefield; age 58.
Winfield S. Kilts, M.D., Teaneck; age 76.
Romola Lyons, M.D., Englewood; age 73.
Howard M. Meyer, M.D., Waterloo, Ontario, Canada (formerly of Hackensack); age 62.
John W. Prather, M.D., Rhinebeck, N. Y. (formerly of Dumont); age 62.
Arthur A. Scullion, M.D., Cliffside Park; age 57.

CUMBERLAND COUNTY

George A. Davies, M.D., Elmer; age 79.
Alfred G. Sheppard, M.D., Elmer; age 75.

ESSEX COUNTY

Rush C. Bauman, M.D., Nutley; age 72.
Stella S. Bradford, M.D., Montclair; age 86.
William J. Bull, M.D., Montclair; age 67.
Edwin G. Dewis, M.D., Asbury Park; age 65.
Raymond T. Potter, M.D., West Orange; age 66.

MERCER COUNTY

Enoch Blackwell, M.D., Yardley, Pa. (formerly of Trenton); age 81.
Paul B. Means, M.D., Levittown, Pa. (formerly of Trenton); age 65.

MIDDLESEX COUNTY

Pauline A. Long, M.D., New Brunswick; age 76.
Samuel Messinger, M.D., Miami Beach, Fla. (formerly of Carteret); age 70.
Laurence P. Runyon, M.D., New Brunswick; age 80.
George W. Tyrrell, M.D., Perth Amboy; age 87.
Robert B. Walker, M.D., Oakland Park, Fla. (formerly of New Brunswick); age 68.

OCEAN COUNTY

J. Edwin Obert, M.D., North Palm Beach, Fla. (formerly of New Egypt); age 55.

UNION COUNTY

Maynard G. Bensley, M.D., Summit; age 68.
Cadwell B. Keeney, M.D., Summit; age 76.
Lindley H. Leggett, Jr., M.D., Westfield; age 63.
Milton A. Shangle, M.D., Elizabeth; age 78.

Finance and Budget

(Reference Committee "B")

David B. Allman, M.D., Chairman, Atlantic City

Any report of the Committee on Finance and Budget prepared in advance of the end of the fiscal year must be tentative and general in character. Only after completion of the fiscal year (May 31) does it become possible to speak in precise terms of the year's finances.

From our point of view this has been a sound and satisfactory year, as we expect to demonstrate when the report on the current year's budget and the proposed budget for 1957-58 are presented at the opening session of the House of Delegates.

Publication

(Reference Committee "B")

J. Lawrence Evans, Jr., M.D., Chairman, Leonia

Again the Publication Committee makes no request for funds. Next year, as this year, we will operate on our accumulated reserves and not need any of the members' dues money. Actually, in 1956 The Journal enjoyed a net income from advertising, subscription, and sales amounting to $43,420. Since it cost $49,137 to print, bind, and distribute The Journal, there was a book loss of $5,717. Accounts Receivable as of December 31, 1956 amounted to $6,478.

Our publication is becoming one of the better known state medical journals. Requests for permission to reprint our lively editorials continue to come in from the four corners of the nation. Last year's unique "Authors' Clinic" has caught the attention of the Ronald Press Company in New York and now forms the basis for a guide to medical writing, published this spring by that company under Dr. Davidson's authorship. This book, developed from columns in this Journal, now constitutes the house manual for the medical publications of the Ronald Press.

Another innovation this year has been the development of a regular series of historical articles, authored by various members of the Society, lighting up some of the lesser known corners of medical history. One of them, the article called "His Name Was Mudd" has won the accolade of inclusion in the 1956 British Bibliography of Medical History.

During 1956 The Journal published 594 pages of text and 774 pages of advertising for a total of 1368 pages. The 594 pages of text break down as follows:

312	pages of Original Scientific Articles
25	pages of Historical Articles
123	pages of State Activities
36	pages of Editorials
20	pages of Book Reviews
7	pages of Authors' Clinic
29	pages of County Society Reports
15	pages of Announcements
4	pages of Woman's Auxiliary material
23	pages of other material
594	

The Transactions of the 190th Annual Meeting were published as a 100 page supplement to the September issue.

We think that the Society has reason to be proud of The Journal. It is an instrument of communication between the officers and members of our organization. It is a worthy representative of New Jersey in the gallery of state medical journals. It is a permanent archive of New Jersey medicine. It continues as an educational organ, keeping the New Jersey physician in pace with the latest advancement in medicine.

Annual Meeting

(Reference Committee on Miscellaneous Business)

Jerome G. Kaufman, M.D., Chairman, Newark

The Annual Meeting Committee and Section Officers met last fall to formulate the scientific program for 1957. The Sections on Orthopedic Surgery and Pediatrics will not meet this year.

The other eighteen sections have planned excellent programs. We hope the membership takes full benefit from them by attending the various meetings.

A special session on mental health has also been scheduled which will feature a film now in production, and a nationally prominent speaker. This program is offered through the courtesy of Smith, Kline and French Laboratories.

The committee urges that all who attend the annual meeting visit the scientific and technical exhibits. They will contain information of interest and will be presented in an attractive manner.

The House of Delegates has previously approved the following convention dates which have been confirmed with Haddon Hall:

1958—Saturday, May 17—Wednesday, May 21
1959—Saturday, April 25—Wednesday, April 29
1960—Saturday, May 14—Wednesday, May 18

The exact dates for the 1961 annual meeting depend upon the dates of the A.M.A. meeting which, in 1961, will be held in the east. Therefore, our recommendation refers to place only, the time to be determined later.

RECOMMENDATION

That the 195th annual meeting of The Medical Society of New Jersey be held at Haddon Hall, Atlantic City.

Scientific Exhibit

(Reference Committee on Miscellaneous Business)

William W. Hersohn, M.D., Chairman, Atlantic City

The exhibit has been oversubscribed, and the first thirty-two exhibitors were accepted. This year there are a larger number of New Jersey physicians represented than in previous years.

The same two classes of awards will be offered, but the number has been reduced from six to four plaques in view of the modest size of the exhibit.

Scientific Program

(Reference Committee on Miscellaneous Business)

Edward E. Seidmon, M.D., Chairman, Plainfield

At a meeting early last fall, the Scientific Program Chairman, with the Section Officers, organized the Scientific Program for the 1957 annual meeting. The Sections on Orthopedic Surgery and Pediatrics indicated that they would not present programs this year.

The section programs were completed by December and published in the January Membership *Newsletter*.

We believe the Scientific Program this year will be outstanding, and we hope the members will attend the sessions.

Advisory to Woman's Auxiliary

(Reference Committee on Miscellaneous Business)

L. Samuel Sica, M.D., Chairman, Trenton

Last June the Advisory Committee considered the program of the Woman's Auxiliary for the year. With few amendments, the program was approved by the committee and the Board of Trustees.

In addition to the many and varied continuing activities of the Auxiliary, several new projects were undertaken. Among them were the collection of biographies of members of The Medical Society of New Jersey to supplement the data now available through the Membership Directory; the monthly publication of a Membership News Note to carry to all Auxiliary members news of Auxiliary activities at all levels; and active support of the Medical Student Loan Fund of this Society. Increased activity was programmed in the fields of Chronic Illness, Civil Defense, Nurse Recruitment, Annual Meeting, Organization and Membership, Safety, and Press and Publicity.

Under the direction of committees of the Medical Society, the Auxiliary has been active in the fields of Legislation, Public Relations, and Community Health. In connection with the latter, the Auxiliary sponsored a program of health movies at the New Jersey State Fair for the second year. The program has been well received, and it is hoped there will be increased interest in future programs.

There is ever-increasing evidence that the Woman's Auxiliary desires above all else to be of service to The Medical Society of New Jersey. We appreciate the way in which the Auxiliary cooperates in the Society's programs and plans.

Honorary Membership

(Reference Committee on Resolutions and Memorials)

Aldrich C. Crowe, M.D., Chairman, Ocean City

No names have been submitted for honorary membership in The Medical Society of New Jersey. Therefore, it has not been necessary for the committee to meet this year.

Welfare

(Reference Committee "E")

Kenneth E. Gardner, M.D., Chairman, Bloomfield

The Welfare Committee held three meetings during the current year at which were considered the reports of its subcommittees on Legislation, Public Health, Medical Practice, and Public Relations, and of its special committees on Cancer Control, and Maternal and Infant Welfare. Following approval by the Welfare Committee, the recommendations of the subcommittees and special committees were then transmitted to the Board of Trustees for final approval and adoption. The individual reports of the subcommittees and special committees will appear as separate reports.

The problems of military dependents' medical care (Medicare) were discussed by the Welfare Committee as a whole at two of the meetings. This program is important to every practicing physician, and directives will be issued from time to time to keep the medical profession informed about the program.

Maternal and Infant Welfare

(Reference Committee "E")

JOHN D. PREECE, M.D., Chairman, Trenton

The work of the Committee this year consisted of its usual duties of reviewing and classifying the maternal deaths throughout the state in conjunction with the Bureau of Maternal and Child Health of the New Jersey State Department of Public Health.

In addition steps were taken to focus more attention on the drive to reduce infant mortality in the State. Recommendations were made that statistical analyses of perinatal deaths be compiled by all hospitals in the State, and that these statistics be reviewed in combined meetings of the Obstetrical and Pediatric Staff of each hospital.

Our final meeting of the year will take up the subject of classification of infant deaths. This project shall be continued into the coming year in an attempt to dispel the confusion that prevails in the statistical reports of the different categories of perinatal mortality. The terms: "abortion," "stillbirth," "live birth," and "prenatal death" are not defined in the same way by all hospitals. Consequently they do not lend themselves to a uniform method of classification throughout the State. In 1957-58 an effort will be made to achieve such uniform method of classification.

Cancer Control

(Reference Committee "E")

GEORGE P. KOECK, M.D., Chairman, Newark

This committee held bi-monthly meetings during the past year, and since the committee also comprises the Medical Committee of the American Cancer Society, New Jersey Division, Inc., the meetings were held jointly.

The committee conducted a survey of cancer clinic activities for the past three years, and after studying the progress made in the establishment of clinics up to the present the following conclusions were reported:

The American Cancer Society, New Jersey Division, Inc., should adopt a conservative attitude toward the establishment of additional cancer clinics in areas where there are already facilities. It has been shown that, in general, present clinics could carry a larger load if referrals increase. With few exceptions, clinics operate on a one-session-a-week basis, and it would be more economical to increase the number of sessions than to establish another clinic. It would seem more practical to anticipate an increase in subsidy payments than to buy additional equipment which may be necessary to open a new clinic.

There appears to be a need for at least one clinic in each county. Therefore, efforts to establish cancer clinics in Ocean, Warren, and Somerset counties may be justified if county medical society support is obtained. More promotion of the use of the cancer clinics now established is indicated. This would be in the way of interesting more and more physicians in the clinics.

The New Jersey Division's program MD-CANCER, will certainly have long-range results in this direction. A policy of conservatism will not preclude consideration of clinics being set up in hospitals where there is good evidence of enthusiastic support by the hospital and its doctors in such an activity and where the establishment of such clinics would not be a duplication of facilities within an area. The total number of tumor clinics in New Jersey is now 48.

Under the direction of this committee, and with the approval of the Medical Society, a professional information program for physicians, MD-CANCER, is being conducted in the hospitals of New Jersey. Briefly, this program provides the services of a staff member of the New Jersey Division of the American Cancer Society who conducts a program for any number of physicians who wish to gain the latest information on cancer. From September 1, 1956, when this program was in-

augurated, to March 1, 1957, 126 meetings were held in 33 different hospitals, with a total attendance of 2,162 physicians and 361 nurses. We anticipate that 100 or more additional programs will be given before the summer of 1957.

This committee considered the establishment of a cancer commission in New Jersey as recommended by the American Medical Association. The purposes of the resolution were approved by the committee, but it was felt that the duties of a cancer commission as outlined were already proper to the Committee on Cancer Control and that the formation of such a commission was therefore unnecessary.

The fourth Annual Cancer Seminar for New Jersey physicians was held in November 1956 under the co-sponsorship of the American Cancer Society and The Medical Society of New Jersey.

Subcommittees • • •

Public Relations

(Reference Committee "E")

Samuel M. Diskan, M.D., Chairman, Atlantic City

The Subcommittee on Public Relations, with the approval of the Board of Trustees, assumed responsibility for evaluating and suggesting programs and projects calculated to further the public relations of The Medical Society of New Jersey as regards the relation of doctor-and-doctor and doctor-and-patient, and the relations of medicine as an organized unit with the general public.

Continuing Projects

The continuing projects of the subcommittee were:

1) Publication and distribution of the membership guide booklet.
2) Publication and distribution of the *Junior Health Hints* to schools, *Health Hints* to the press, *Membership Newsletter,* and *Periodic Newsletter* to cooperating agencies.
3) Re-evaluation of project coverage, *i.e.,* the emergency medical service program.
4) Encouragement of indoctrination programs at county level.
5) Consultative service in support of county society PR activities.

PR Emphasis for Year

It was agreed that this year primary emphasis should be placed upon the fact that every individual doctor is an essential factor in the achievement of good public relations for Medicine, and what the individual doctor says and does will largely determine his patient's impression of the worth of the entire profession. The subcommittee agreed that throughout the year constant stress should be placed upon this concept.

County Indoctrination Program

A uniform indoctrination program is being prepared under the direction of the subcommittee for utilization by all component county societies, for the purpose of introducing new members to the responsibilities and advantages of membership in The Medical Society of New Jersey and its component societies.

"The Case of the Doubting Doctor"

As a means of assisting the average member in better understanding his relationship to organized medicine, The Medical Society of New Jersey, through the Subcommittee on Public Relations, purchased a copy of "The Case of the Doubting Doctor," a 16 mm. color film produced by the American Medical Association, and made it available for presentation before county medical societies.

County Meeting Attendance Record

Every county medical society was requested to compile a detailed attendance record covering all regular meetings, and to send a copy of that compilation annually to the Executive

Offices to assist the state society officers in making dependable appointments to the committees of The Medical Society of New Jersey.

Code of Cooperation

In view of the fact that the New Jersey Press Association, through its Board of Directors, recorded its willingness to "extend to The Medical Society of New Jersey any help the Society might require if the Society is undertaking a new program to improve medico-press relations, "—a joint committee on press relations was formed, made up of equal membership from the Subcommittee on Public Relations and the New Jersey Press Association. The function of this joint committee is to work out a code of cooperation to be submitted for adoption by the parent organizations.

Sponsorship of Poster Contests

As a very simple yet effective means of achieving good publicity and public relations for medicine, the sponsorship of medical poster contests was endorsed, with the recommendation that The Medical Society of New Jersey seek the cooperation of the Woman's Auxiliary in conducting a series of contests at county level. The winners would compete at state level, and would be presented in the course of the annual meeting each year.

Service Plaques for 50-Year Practitioners

So that some official recognition may be given by The Medical Society of New Jersey to members who have completed 50 years of practice, it was recommended and approved that The Medical Society of New Jersey establish an award to be made at the annual meeting. The first such bestowal is scheduled for this year's annual meeting.

Questionnaire on County Society Meetings

A questionnaire has been sent to all component county societies asking for details of the management of county society meetings, with particular emphasis upon technics that have proved successful in improving membership attendance. It is the thought of the subcommittee that from the information thus gleaned, constructive suggestions might be made for the possible improvement of meetings of all component societies.

Projects Under Consideration

Projects suggested for future activation by the subcommittee were:

a) Consideration of the desirabilty of recommending the establishment of a Poison Control Center (or centers) in New Jersey.

b) A study of the New Jersey State Science Fairs for possible participation by The Medical Society of New Jersey.

This chairman wishes to thank committee members Dr. Howard C. Pieper, Dr. Harry F. Suter, and Dr. John F. Kustrup for their conscientious and dedicated services; and Mr. Nevin and Mrs. Edith Madden and their staffs for their invaluable services. We appreciate the wise counsel of Dr. Lewis Fritts who devoted much time to our committee meetings. We feel privileged to have been instrumental in translating some of the so many written and spoken words of committee work into physical action. It has been a pleasure to serve you as chairman of this committee during this past year.

Medical Practice

(Reference Committee "E")

Irving Klompus, M.D., Chairman, Bound Brook

The Committee held four meetings in Trenton. The following matters were discussed and action taken as indicated:

(1) Old Age Assistance—There has been great dissatisfaction with the manner of compensation for medical service in Old Age Assistance cases. It is expected that after July 1, 1957, it will be possible to pay doctors directly for their services.

(2) Fees and Fee Schedules — There is a continuing study of fee schedules. The subcommittee feels that it is in the interest of the profession that there be set up some means of assessing relative values of medical services.

(3) Disability and the Social Security Law of 1956—The available information is being studied in order that the profession might have some idea of possible problems of a medi-

cal nature that may develop when the law becomes operative July 1, 1957. It is our recommendation that each county establish a committee to review cases of disputed disability.

(4) Definitions—Definitions of Ophthalmologist, Optometrist, Opticians are being worked up for the clearer understanding of the profession.

(5) Prescription Refills — The Board of Trustees approved our recommendation that a uniform system be adopted whereby all prescription blanks be printed with legends to be checked by the prescriber indicating his desires with respect to the refilling of such prescriptions.

SPECIAL COMMITTEE OF THE MEDICAL PRACTICE COMMITTEE

Workmen's Compensation

(Reference Committee "E")

FREDERICK G. DILGER, M.D., Chairman, Hackensack

The Special Committee on Workmen's Compensation, during its meetings this year, has considered steps to be taken to improve the quality of medical testimony in the Division of Workmen's Compensation.

It was the consensus of the committee that the quality of medical testimony would be improved if it were possible to obtain the testimony of treating physicians. Many doctors who have treated injured workmen avoid appearing before the Division at formal hearings. We feel that they should not treat such cases if they are unwilling to testify as to the results of such treatment.

We feel further that the compensation for physicians appearing for the petitioner should not be on a "contingent fee" basis as at present, nor should its amount be based on the size of the award as at present, since this leads to exaggerated estimates of disability.

Recommendations:

1. That under proper auspices, closer cooperation be maintained between the Society and the Division of Workmen's Compensation of the Department of Labor and Industry for the purpose of improving the quality of medical testimony.
2. That the component societies arrange for instructional courses or lectures on Evaluation of Disability.

Public Health

(Reference Committee "E")

SAMUEL BLAUGRUND, M.D., Chairman, Trenton

The activities of the subcommittee on Public Health this year have been many and varied. In addition to considering the reports of its seven special committees, the subcommittee considered and reported on several referrals from the Board of Trustees. Members of the subcommittee have met with other committees of the Society on matters of legislation, chronic illness, and mental health. Also various meetings of State agencies on matters of concern to the Medical Society have been attended by members of the subcommittee. All in all, the year has been a busy one, and while we cannot point to any one specific project as totally accomplished, we can point with pride to the progress made toward total accomplishment.

Several years ago the Society adopted a policy that it will not endorse any organization in which it does not have a vote in establishing policies. The subcommittee felt the policy expressed a negative approach to the

problem and offered the following substitute, which was approved by the Welfare Committee and the Board of Trustees:

> We hereby recommend to all lay groups interested in community health that requests be made of The Medical Society of New Jersey for the appointment of liaison personnel to their organizations so that medical viewpoints will be properly considered in the planning stages of their committee activity, thus by preconsultation hasty acceptance of a worthy project will not be necessary—consultation in no way implying endorsement; and that the presidents of these public health groups be so notified.

The activities of the several special committees will be covered in their individual reports. They have all had increased activity this year and have done a fine job.

The members of the subcommittee and of the special committees have worked hard. They have given full interest in their assignments, willingly given up their time for meetings, and in every way have cooperated splendidly. The reports of their studies, investigations, and discussions are significant of their interest in and responsibility for the work of the Society in the field of public health. As chairman, I wish to express my appreciation for their efforts.

SPECIAL COMMITTEES OF THE PUBLIC HEALTH COMMITTEE

Chronically Ill

(Reference Committee "E")

William H. Hahn, M.D., Chairman, Newark

The Special Committee on the Chronically Ill held two meetings during the year 1956-1957. The Committee continued its interest in the medical supervision of nursing homes. This concern was originally brought to the Medical Society by the representatives of The Licensed Nursing Homes Association of New Jersey, Inc.

A conference, attended by officers of The Medical Society of New Jersey, members of the Committee on Chronically Ill, and representatives of the State Department of Institutions and Agencies, was held in the Spring of 1956. It was recommended that a similar conference be held this year. This conference was held in January, 1957.

The committee feels that the material submitted by the Commissioner of the State Department of Institutions and Agencies, covering present rules and regulations, and the suggestions for new regulations, governing medical care in Nursing Homes, together with the request for help in devising a fee schedule for the new Old-Age Assistance program, requires further study.

Recommendation:

Continued and renewed efforts to stimulate the formation, and to support the operation, of committees on the chronically ill in all component societies.

Conservation of Hearing and Speech

(Reference Committee "E")

S. Eugene Dalton, M.D., Chairman, Ventnor City

The Special Committee on the Conservation of Hearing and Speech has made splendid progress during the year.

The Henry Barkhorn Memorial Center in Newark has increased the scope and efficiency of its institution.

The Trenton Conservation of Hearing and Speech Research Center has been located in the St. Francis Hospital. Rooms have been set aside, and they will be furnished by the hospital. The hospital has also purchased a sound proof room to be installed. The technical equipment has been purchased by the New Jersey State Department of Health. A hear-

ing and speech technician-therapist is now being sought to take over the position at the center. The salary of the technician-therapist will be paid by the Trenton Junior League.

A motion to establish a Conservation of Hearing and Speech Research Center at the Atlantic City Hospital was adopted by the major staff and approved by the Board of Governors. The hospital has set aside and reconditioned three rooms for the purpose. It has built a noise-proof room within one of the rooms and will provide the necessary desks, chairs, and filing cabinets. It will also equip one room with an E.N.T. diagnostic and treatment unit. The New Jersey State Department of Health has purchased the technical equipment for the center and will pay the salary of a technician-therapist. It is expected that the position will soon be filled.

Our goal for the coming year is continued progress.

Conservation of Vision

(Reference Committee "E")

A. M. K. Maldeis, M.D., Chairman, Camden

The work of the Special Committee on the Conservation of Vision during the year about to close has been based upon a number of varied factors, among which is the desire for fuller and better understanding of the work of the ophthalmologists by the public and physicians in general. Accomplishments of our aims and purposes cannot be had in a year's time. We have tried to lay a few constructive plans which through the continuous efforts of the eye physicians, we hope will be worthy of fulfillment.

In order that the relationship of ophthalmologists to all other physicians and to the general public may be more fully understood, an article upon the subject will be prepared for publication in The Journal.

The screening of vision of the school children of New Jersey continues as a subject for discussion. Naturally no state or county programs can be made uniform as long as divided responsibility and direction continue. As to the tests used, it is still felt that the basis for visual screening, and the most important single test, is the Snellen Test. There are modifications of this test—such as the Atlantic City and Massachusetts Tests—which are satisfactory. It is to be stressed that the school screening procedure concerns itself exclusively with the determining of visual acuity. It should not be interpreted as giving assurance concerning other eye conditions. The responsibility of the parent in the matter of the determination of the entire physical condition of the school child might well be more strongly emphasized, so as to minimize the rapidly increasing tendency of shifting the responsibility of the parent over to social and governmental agencies. This committee feels that uniform county and state direction of school eye examinations would be more satisfactory under the leadership of the physicians of New Jersey.

The Board of Trustees of The Medical Society of New Jersey has authorized a statewide program of eye health screening in 1957 under the co-sponsorship of The Medical Society of New Jersey and the New Jersey Academy of Ophthalmology and Otolaryngology. The New Jersey Commission for the Blind will be invited to cooperate.

Proposals for and enactment of State Legislation have upon occasions included action which could seriously affect the practice of medicine, particularly the specialty of ophthalmology. A joint meeting was held between this committee and the Subcommittee on Legislation. It resulted in the framing of a resolution, subsequently approved by the Board of Trustees, "That the official position of The Medical Society of New Jersey be, that no reference to physicians should appear in legislation affecting optometry other than such reference as occurs in specific exclusions of the applicability of such laws to physicians."

The toll of highway accidents is one of general concern. Toward relief of this problem, our committee requested The Medical Society of New Jersey to offer to the Director of the Division of Motor Vehicles of the State of New Jersey whatever assistance the committee might be able to give. Such offer has been extended. It would seem that medicine as a whole might play a larger part in this area of public service. Several members of the com-

mittee have had the opportunity of meeting with the Director in relation to this matter.

Industry is a field with which there should be a closer contact in the interest of the conservation of vision. An article is being prepared telling of the progress in this area made in recent years, particularly in relation to industry. Upon approval by The Medical Society of New Jersey, such article would become available for distribution to industrial management.

Miscellaneous matters, such as requests by the public for explanation of ocular terms used in T.V. programs, have been taken care of. The dangers to the eyes of the public through use of some proprietary medicines also came to the attention of our committee and have been referred for further investigation.

Mental Health

(Reference Committee "E")

Robert S. Garber, M.D., Chairman, Princeton

The following matters were considered by the Special Committee on Mental Health during 1956-57:

TRANQUILIZING DRUGS

These drugs are still in the formative stage, and they continue to require comprehensive medical supervision. Their promiscuous use is deplored. Their use has increased personnel services to the mentally ill and has revealed need for more personnel in institutions. Endeavor is being made to resolve the problem created when patients are released from mental hospitals with maintenance dose recommended. Interest in the results has stimulated the public to the point where they now look upon mental hospitals as progressive institutions.

MARRIAGE COUNSELLING

The committee considered a proposed piece of legislation which would require marriage counselling for couples contemplating divorce. It reported its opinion that such legislation is progressive.

ANNUAL MEETING MENTAL HEALTH PROGRAM

The committee has arranged a special program on mental health for the 1957 annual meeting.

A nationally known Professor of Medicine will speak on "Psychiatry for the General Practitioner," and the premier showing of a film on the same subject has also been scheduled.

SEMINARS ON PSYCHIATRY FOR GENERAL PRACTITIONER

In furtherance of the program to disseminate information to general practitioners in the field of mental health, the committee assisted the New Jersey Chapter of the American Academy of General Practice in arranging for six seminars at Princeton University this spring. The seminars will feature 18 prominent psychiatrists and internists.

COMMUNITY MENTAL HEALTH PROGRAM

The committee reviewed and approved proposed legislation, sponsored by the New Jersey State Department of Institutions and Agencies, for the establishment, improvement, development, and expansion of community mental health services, appointment of county mental health boards, and to provide for the payment by the State of financial grants-in-aid for such community mental health projects. The proposed legislation has been referred to the Subcommittee on Legislation for consideration.

LEGISLATION ABOUT PSYCHOLOGISTS

Proposed legislation for licensing psychologists was studied by the committee. The Subcommittee on Legislation also has this matter under consideration.

PSYCHIATRIC SERVICES IN GENERAL HOSPITALS

The committee again stressed the need for psychiatric services in general hospitals, and outlined the problems faced in getting the pro-

gram under way. This re-emphasized the recommendation made to all general hospitals a few years ago by The Medical Society of New Jersey. The matter has been referred to the Medical-Hospital Liaison Committee for consideration and possible action.

MATTERS PENDING

In cooperation with the New Jersey Neuropsychiatric Association the committee has under study:

1. Legislation on amendments to Beadleston Bill
2. Fees for psychiatric services under the VA contract
3. Possible alteration of procedure for examination of automobile drivers suspected of convulsive disorders.

Rehabilitation

(Reference Committee "E")

ELMER J. ELIAS, M.D., Chairman, Trenton

Progress is reported on the following program of the Special Committee on Rehabilitation:

1. Education of physicians as to the significance of rehabilitation by means of:

A. Establishment of a committee on rehabilitation by each county medical society.
B. The designation of a meeting on rehabilitation by each county medical society.
C. Investigation and surveying of facilities available in all communities as to source of patients and treatment facilities.

2. A meeting of the committee with county chairmen to discuss county problems in the field of rehabilitation.

Rehabilitation is assuming greater importance and has the active support of government officials. Our committee hopes through its program to provide understanding and promote interest in the problem of rehabilitation of disabled persons in our State by the medical profession.

Physicians Placement Service

(Reference Committee "D")

MARCUS H. GREIFINGER, M.D., Chairman, Newark

The operation of the Physicians Placement Service has continued in a routine manner. Physicians desiring locations in New Jersey are listed, as well as communities in need of additional physicians. Wider distribution of the summary reports has been made during the current year. In compliance with the directive of the 1956 House of Delegates, the quarterly reports are forwarded to all county societies, and the editors of THE JOURNAL and the Membership *News Letter* of The Medical Society of New Jersey, in addition to other, interested parties.

During the current administrative year 172 physicians have contacted the Placement Service. The following statistics show the medium through which contacts were made:

Referrals from the A.M.A.	73
Direct mail	82
Personal visits and telephone	17

Twenty-two of these physicians have located within the state, 30 are now practicing in another state, 63 failed to reply to our follow-up communications, and 57 names are still carried in the active file.

The Physicians Placement Service makes use of several methods to assist its registrants to locate in New Jersey. For those who wish to establish private practice, we maintain a list of New Jersey communities in need of additional physicians. During the year one new community was added to this list, for a maximum of 45 communities listed, with 8 placements and 37 remaining unfilled.

Registrants desiring to associate with, or serve as assistants to, physicians engaged in active practice are also listed. 22 New Jersey physicians contacted the service in an attempt to secure an assistant or associate. Any physician contacting the Physicians Placement Service to aid him in his search for an assistant or associate is provided with a list of registrants and is requested to make direct contact with anyone so listed whose qualifications seem satisfactory. For that reason, it is difficult to estimate the number of placements made as a result of this phase of the program.

During September, 1956, contact was made with the Personnel Director of the N. J. State Department of Institutions and Agencies in an attempt to serve those physicians interested in institutional employment. We are now in position to assist many more physicians than we were previously, because of this additional contact.

Full cooperation is extended to members' widows desiring to dispose of equipment or practices. Upon request, lists of registrants are supplied and direct contact can then be made.

Operation of the Physicians Placement Service continues to be carried out by the office staff as a routine duty. No charge is made for any service rendered, and the cost to the Society of maintaining the program is minimal.

Widows and Orphans of Medical Men

(Reference Committee "D")

HARRY H. FARB, M.D., Chairman, Newark

No new problems were brought to the attention of this Committee during the past year. There are no recommendations.

Medical Student Loan Fund

(Reference Committee "B")

F. Clyde Bowers, M.D., Chairman, Mendham

There have been no meetings of this Committee during the current year because the amount of money available to us was too small to establish a program of loans to deserving medical students. The Woman's Auxiliary, however, has not been idle; on the contrary, it has sponsored a program for the raising of funds for this purpose. Also, it is expected that The Medical Society of New Jersey will provide additional monies during the ensuing year when it is hoped that this Committee may begin to function in a productive manner.

Amendments to Constitution • • •

(Reference Committee on Constitution and By-Laws)

ARTICLE VI—BOARD OF TRUSTEES

The following proposed amendment to the Constitution was approved by the House of Delegates at the 1956 Annual Meeting, recognizing that such amendment must be considered by the House of Delegates for final vote in 1957. In compliance with the Constitutional provision regarding amendments, the proposal was sent to each component society and published in The Journal in January, 1957.

Delete Article VI of the Constitution and replace Article VI with this amendment:

Section 1: The Board of Trustees shall be the executive body. It shall be composed of the immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and twenty-one (21) members. Each member shall be elected from and by his component county society prior to the annual meeting of the House of Delegates. Each member shall be elected for a term of three (3) years, such term to commence upon the expiration of the term of the former incumbent. The term of office of seven members shall expire annually.

Section 2. Provided that within thirty days following the adoptions of the amendments, the first seven (7) counties alphabetically, from Atlantic through Essex, shall elect for one (1) year, the second seven (7) counties, from Gloucester through Morris, for two (2) years, and the third seven (7) counties, from Ocean through Warren, shall elect for three (3) years. Thereafter, at the expiration of those terms each Trustee shall be elected for three (3) years. After two (2) years Article VI, Section 2 shall be automatically deleted from the Constitution without further amendment. Members of the present Board of Trustees shall hold office until their successors are elected.

Section 3. Any member as classified in Article VI, Section 1, may be elected a Trustee for a maximum of three (3) full terms provided, however, that if the first two (2) elected terms are successive there shall be a lapse of at least one (1) year between expiration of the second and commencement of the third terms.

Section 4. In the event that the office of any member becomes vacant for any reason the component county society wherein the vacancy exists shall elect a member within 90 days to fill the unexpired term.

Resolutions • • •

Corporate Practice of Medicine

(Reference Committee "E")

From the Monmouth County Medical Society

From the Burlington County Medical Society

Whereas, in 1956 Reference Committee "C" acknowledged that pathologists, radiologists, and physiatrists are physicians engaged in the practice of medicine. In some instances some of them are actually engaged in the corporate practice of medicine, together with hospitals, and as such are practicing unethically as judged by present standards of the American Medical Association. The Reference Committee suggested that the subject be referred to the Board of Trustees with the recommendation that immediate and definite steps be taken to arrive at an understanding between the hospitals and physicians concerned.

Whereas, The attorneys general of many states have declared the corporate practice of medicine illegal. Definite steps have been taken in most of these states including Iowa to abolish the corporate practice of medicine; be it

Resolved, that the Monmouth (Burlington) County Medical Society again go on record as requesting that The Medical Society of New Jersey take immediate and definite steps to prohibit the corporate practice of medicine in New Jersey by May, 1958; be it further

Resolved, that a copy of this resolution be sent to The Medical Society of New Jersey and to the American Medical Association.

Doctors of Osteopathy

(Reference Committee "E")

From the Bergen County Medical Society

Whereas, some osteopaths have obtained the degree Doctor of Medicine (M.D.) from schools not recognized by the American Medical Association and therefore not recognized by the State Board of Medical Examiners of New Jersey; and

Whereas, some osteopaths claim they are Doctors of Medicine in addition to being Doctors of Osteopathy; and

Whereas, some osteopaths make use of the word Doctor or letters Dr. on signs, stationery, prescription pads, bill heads, professional cards, in telephone and other directories, etc., and never show the degree Doctor of Osteopathy; and

Whereas, the word Doctor and letters Dr. when used alone, have come if not to mean at least to suggest Doctor of Medicine when used by a person in a health profession; and

Whereas, the words physician and surgeon when used singly or in combination and not accompanied by a degree, imply or suggest the association with Doctor of Medicine; therefore be it

Resolved, that the Bergen County Medical Society initiate action by presenting this resolution to The Medical Society of New Jersey at the Annual Convention in April, 1957, for legislation through the Legislature of the State of New Jersey to require a person or persons in a health profession to:

1. Display prominently the degree under which he is licensed to practice; this being also the degree which entitled him to take the State Board Examinations.
2. Prohibit him from displaying or using a degree which would give a false impression of his qualifications.
3. Prohibit the use of any degree under which he is not licensed to practice.
4. Prohibit the omission of a degree in all professional senses, which would in effect, give a false impression to the public of his qualifications and/or degrees.
5. Prohibit the use of the word Doctor and letters Dr. on signs, stationery, prescription pads, bill heads and in all other professional capacities including telephone and other directories without also using the degree under which he is licensed to practice.
6. Make mandatory the use of the word osteopathic before the word or words physician and/or surgeon whenever and wherever used by Doctors of Osteopathy.

Essay Contests

(Reference Committee "E")

From the Union County Medical Society

Whereas, for the 11th year the Association of American Physicians and Surgeons is sponsoring an essay contest for high school students in the interest of American medicine, offering as alternate titles "The Advantages of Private Medical Care," or "The Advantages of the American Free Enterprise System"; and

Whereas, for several years the American Medical Association has cooperated in these contests by furnishing thousands of reprints of source material to contestants for a package library service; and

Whereas, many state medical associations and county medical societies or their auxiliaries are directly sponsoring this contest in their respective areas; and

Whereas, this contest offers organized medicine an opportunity to participate in educating not only the contestants but their families and friends and the general public in the value of the American free enterprise system; therefore, be it

Resolved, that The Medical Society of New Jersey does hereby commend the establishment of such essay contests.

Hospital Service Plan Medical Services

(Reference Committee "C")

From the Mercer County Medical Society

Whereas, it is evident that payments of certain medical services, such as Radiology, Pathology, Anesthesiology, Physical Medicine, and Electrocardiography, are now incorporated in Blue Cross Hospitalization Plan of New Jersey contracts for direct payment to the subscribing hospitals; and

Whereas, this concept is foreign not only to our ethical principles, but also to those of the American Medical Association; be it

Resolved, that the Mercer County Component Medical Society be on record as demanding the deletion of such payments for medical services from the Blue Cross Hospitalization Plan of New Jersey and any other statement in the Blue Cross contract implying coverage of medical services; and that such services be included in the Blue Shield Medical-Surgical Plan of New Jersey; and, be it further

Resolved, that a copy of this resolution be sent to The Medical Society of New Jersey for appropriate action.

Hospital Service Plan Medical Services

(Reference Committee "C")

From the Monmouth County Medical Society

From the Burlington County Medical Society

Whereas, in 1955 the House of Delegates of The Medical Society of New Jersey directed that The Medical Society of New Jersey recommend to the Medical-Surgical Plan of New Jersey the inclusion of x-ray treatments for cancer as an eligible service to in-patient, ambulatory, out-patient, or non-hospital patients, if actuarially feasible.

Whereas, in 1956 the House of Delegates approved, in principle, the resolution from eleven county medical societies demanding the deletion of payment for medical services from

the Blue Cross Hospitalization Plan of New Jersey and any other statement in the Blue Cross contract implying coverage of medical services, and that such services be included in the Blue Shield Medical-Surgical Plan of New Jersey.

This was referred to the Board of Trustees of The Medical Society of New Jersey in conjunction with the Board of Trustees of the Medical-Surgical Plan for consideration.

Whereas, Pennsylvania, Massachusetts, New York, and Connecticut have already adopted forms of x-ray coverage in their Blue Shield plans; be it

Resolved, that the Monmouth (Burlington) County Medical Society again go on record as requesting that medical services of x-ray and pathology be deleted from Blue Cross and incorporated in Blue Shield Plans both for the hospital and office practice by May, 1958; be it further

Resolved, that a copy of this resolution be sent to The Medical Society of New Jersey and to the American Medical Association.

Medical-Surgical Plan Physician Lists

(Reference Committee "C")

From the Bergen County Medical Society

Whereas, the A.M.A. recently ruled that any consultation of its members with osteopathic physicians is contrary to its standards of ethics; and

Whereas, many specialty societies have reiterated this stand by the A.M.A.; and

Whereas, many county societies have also reiterated the A.M.A. decision; and

Whereas, the Medical-Surgical Plan of New Jersey has included in its lists, most osteopathic physicians in the State; and

Whereas, these osteopathic physicians thereby benefit by a plan organized and sponsored by The Medical Society of New Jersey, although the Plan has not as yet included benefits for services performed by large segments of our own medical profession, such as pathologists and radiologists; therefore be it

Resolved, that in order to correct this incongruous situation, the osteopaths should be excluded from the listing of doctors of medicine, and included only in a distinct and separate listing as osteopaths, in the Medical-Surgical Plan of New Jersey; and be it further

Resolved, that the Board of Trustees of the Medical-Surgical Plan be directed to revise the physician lists immediately.

Medical Service Administration of New Jersey

(Reference Committee "C")

The Board of Governors

During 1956, Medical Service Administration of New Jersey has been active in the operation of the City of Newark Medical Plan.

This Plan provides for services rendered by physicians of the patients' choice on a fee-for-service basis for care of eligible persons confined to their homes by illnesses; it is designed to meet the needs of the indigent and medically indigent of the City of Newark on a reimbursement, rather than on an insurance basis.

The Plan successfully demonstrates the cooperation of an official health agency with a voluntary agency controlled by the medical profession in helping to solve the problem of public medical care of the indigent and medically indigent.

Following are the statistics on number of cases and value of services for 1956 as compared to 1955.

It should be borne in mind that the *indigent* are those whose names appear on the Welfare Rolls of the City of Newark and that the *medically indigent* are those who, in the opinion of the Social Service Bureau of the City Division of Health, while having a sufficient income to meet the routine cost of a satisfactory standard of living, do not have sufficient income to pay for adequate medical care.

INDIGENT (RELIEF) PERSONS

Year	1955	1956
Mean number of persons on welfare rolls during year	5281	3884
Number of cases during year	1964	1277
Value of approved services	$6,565.50	$4,605.00
Cost per capita of relief load per year	1.24	1.19
Cost per case per year	3.34	3.60

MEDICALLY INDIGENT CASES*

Number of cases during year	3335	2993
Value of approved services	$11,151.00	$9,969.00
Cost per case per year	3.34	3.33

*The word "case" means family as distinguished from "person" referred to under report on number of indigent on relief rolls.

The drop in indigent and medically indigent cases as compared with 1955 is attributable to the high peak of employment in this area.

An increase in the rate of fees paid to physicians servicing the Newark Medical Plan, effective as of April 1, 1957, will be as follows: from $3.00 to $4.00 for a day visit with $2.00 for each additional patient seen on same visit limited to $10.00 for each call; from $5.00 to $6.00 for a night visit with $3.00 for each additional patient seen on same visit limited to $15.00 for each night call. The night hours will be designated as from 8:00 p.m. to 8:00 a.m.

This adjustment in fees and hours was brought about through the negotiations of the Essex County Medical Society with officials of the City of Newark.

MEDICARE PROGRAM

The Dependents' Medical Care Act, P. L. 569, passed by the 84th Congress, provides for medical care to dependents of military personnel, and became effective December 7, 1956.

This is known as the "Medicare Program," and provides, at the expense of the Federal Government, medical care to dependents of members of the uniformed services while in active service.

The Board of Trustees of The Medical Society of New Jersey, at its meeting on September 9, 1956, designated Medical Service Administration of New Jersey as the Fiscal Administrator to implement the Dependents' Medical Care Act in New Jersey.

Representatives of Medical Service Administration met with officials of the Government's Department of the Army on October 31, 1956 to negotiate a suitable non-profit contract.

The Contract was jointly entered into by The Medical Society of New Jersey with Medical Service Administration of New Jersey as Fiscal Administrator, with the United States of America, Department of the Army, and became effective on November 30, 1956.

Subsequently, Medical Service Administration entered into a contract with the Hospital Service Plan of New Jersey, whereby Medical Service Administration, as Fiscal Administra-

tor, subcontracted to the Hospital Service Plan of New Jersey the performance at cost, of the administrative services under the Prime Contract, which services are being performed in the name of Medical Service Administration.

Medical Service Administration has negotiated with the Government for an advance payment of funds for the operation of the Medicare Program, and has arranged for a special bank account for handling such funds.

With the exception of claim forms, Medical Service Administration handles all correspondence pertaining to the Medicare Program; obtains official signatures on all documents and is responsible for their transmission; Medical Service Administration reviews and advises Hospital Service Plan on all questionable claims involving status of physicians, application of the Fee Schedule or on medical practice, and assigns members of its medical staff as required.

We believe that Medical Service Administration of New Jersey has demonstrated to The Medical Society of New Jersey its value in serving as a medium through which medical care may, by plans or arrangements with governmental authorities at Federal, State or other levels, be made available to individuals and groups not eligible for insurance protection against illness on a non-profit voluntary prepayment basis, preserving the patient-physician relationship and allowing free choice of physician and patient.

Once again, the Board of Governors wishes to express to The Medical Society of New Jersey its appreciation of and gratitude for the continued moral and financial support so generously given to Medical Service Administration over the sixteen years of its existence.

Medical-Surgical Plan of New Jersey

(Reference Committee "C")

THE BOARD OF TRUSTEES

This comprises the fifteenth Annual Report to the House of Delegates of The Medical Society of New Jersey since Medical-Surgical Plan began its operations in 1942.

Each year of operation has resulted in an increase of persons enrolled and in the number of Participating Physicians.

During 1956 there was an increase in enrollment of 146,000 persons for a total estimated enrollment at the end of the year of 1,546,007 subscribers and dependents.

Plan payment to physicians during 1956 amounted to $18,435,205.30. Of this amount, Participating Physicians received 69.9 per cent, Non-Participating Physicians, 20.5 per cent, and Out-of-State Physicians, 9.6 per cent. During its 15 years of operation the Plan has made a total payment of $82,384,442.55 to physicians for eligible services rendered to its subscribers and their dependents.

During 1956 the Plan received earned subscriptions of $22,423,452.72. Of each subscription dollar, 84.5 cents were incurred for claims, 9.7 cents for operating expenses, and 5.8 cents added to reserves.

A summary of operations for each year is attached to this report (Appendix A).

PARTICIPATING PHYSICIANS

The number of Participating Physicians increased by 114 for a total at year end of 5,336. This total represents 79.7 per cent of the physicians in New Jersey who are eligible to be Participating Physicians. A table of participation by counties as of December 31, 1955 and December 31, 1956 is appended to this report (Appendix B).

CONTRACT CONVERSION PROGRAM

During the year the Plan was engaged in converting from the old Series 1949 Subscription Contract to the new Series 1956 Contract. This program began on May 1, 1956 and requires a year for completion. As of December 31, 1956, 84 per cent of the enrollment in force consisted of the new contract and 16 per cent of the old. Conversion to the new contract will be completed on April 30, 1957. The Plan will then be in a position to compile actuarial experience solely on the basis of the new contract.

This program has required the application of a difference in benefits between the old and the new contract. The Schedule of Payments and service reports with respect to the new contract were distributed to physicians and to subscriber groups.

The major benefit changes under the New

Subscription Contract as compared to the old consist of:

1. *Medical Benefits Increased*:

Eligible medical (non-surgical) care in hospital increased from a limit of 21 days in a Contract Year to 21 days per hospital admission, provided that any subsequent hospital admission occurring within 90 days following date of previous discharge shall be deemed to be continuous and to constitute a single period of hospitalization.

2. *Surgical Services in O.P.D. Increased*:

Surgical services rendered in the Hospital Out-Patient Department, without admission of the patient as a bed patient, need no longer be "of an emergency nature" to be eligible for Plan benefit. Instead, surgery of a cutting or cauterizing nature performed in O.P.D. is also eligible to the same extent as such surgery for a bed patient in hospital under the Series 1949 Contract.

3. *Surgical Services Outside of Hospital Increased*:

Under the Series 1949 Contract, there is a maximum eligible payment of $25.00 for emergency surgical services rendered outside of hospital within 48 hours after an accident. Under the new Contract, Plan payment is made in accordance with the surgical schedule to a maximum of $50.00, for surgical services of an emergency nature occasioned by accidental injury which commence within 48 hours after an accident.

4. *Newborn Infant*:

The newborn baby is an eligible person from the date of birth, instead of the seventh day of life.

5. *Consultations*:

Plan payment for eligible consultations is limited to one formal, non-mandatory consultation during any one hospital admission. A Participating Physician who must travel more than 10 miles to render such consultation will not be required to accept Plan payment as full payment for his consultation services, regardless of the patient's income status.

6. *Change in Income Limit for Family Contracts*:

The 1949 Series Contract carries a flat income limit of $5,000 for service benefits, irrespective of the number of people covered by a Contract. This limit applies to the income of the *subscriber only*, regardless of the income of the subscriber's spouse, if any.

The new Series 1956 Contract applies the income limit of $5,000 to *single* person Contracts, but the income limit for all *Family* Contracts is $7,500. Under contracts in which husband and wife are enrolled, the limit of $7,500 includes the combined income of subscriber and spouse.

This change in provision was made to satisfy the request of the House of Delegates to apply the *combined income* of husband and wife to the income limitation for service benefits. The request was made because the income limitation under the Series 1949 Contract was $5,000, regardless of the number of persons covered by that Contract and applied to the *income of the Subscriber only*, who frequently was the wife, and it did not include any income of the husband who was classified as the dependent. Hence, under this situation, it was possible for a family to have a combined income of up to $10,000, or more, and still qualify for service benefits.

The Plan was requested to apply the income limit to the combined income of Subscriber and Spouse at a level of $5,000. After exhaustive study, it was determined that the lowest level at which the Plan could apply the combined income without a reduction in benefits was $7,500. This was arrived at after coordinating the opinions of subscribers, employers, the trade unions, the doctors, and the Department of Banking and Insurance. In addition, a careful study of many reports indicate that the change in the income limit, as adopted, maintains the "service benefit" feature of the Contract for the same percentage of the population to whom it was available when the Plan first adopted the $5,000 income limit.

7. *Direct Payment to Subscriber for Services by Non-Participating Physician*:

Under the terms of the Series 1956 Subscription Contract, the Plan may make payment to the Subscriber when the patient is attended by a physician who is eligible to be, but is not, a Participating Physician. This procedure was twice approved by a large majority of the House of Delegates.

8. *Schedule of Payments Changes*:

Apart from the specific Contract provisions listed above, the Schedule of Payments appli-

cable to the Series 1956 Contract includes provisions for

(a) Increase from a $250 to a $300 surgical schedule with selective increases in payments for various surgical procedures, including restoration of many reductions which were made in 1952.

(b) In addition to the increased number of medical days available under the new contract there is an increase from $25.00 to $35.00 in the special additional allowance for medical services in a critically ill case requiring prolonged or repeated hospital visits within a 48-hour period.

(c) A general increase in payment for eligible anesthesia services.

NON-GROUP ENROLLMENT

Over the years, the public and medical profession of New Jersey have requested the Plan to make available enrollment on a non-group basis. In 1950 a pilot study was made based on such an enrollment opportunity to non-group subscribers of Hospital Service Plan of New Jersey. The response was small and the initial claim incidence high, but the ultimate experience was favorable.

The Trustees of the Plan were desirous of satisfying the demand for non-group enrollment and decided to initiate such enrollment as promptly as possible after the conversion program to the new Contract was proceeding satisfactorily.

The approach to non-group enrollment is divided into two phases. The first consisted of an enrollment opportunity to direct payment subscribers of Hospital Service Plan residing in New Jersey. This phase took place in November, 1956, when applications for non-group enrollment were mailed to all direct payment subscribers of Hospital Plan for Contracts with Medical-Surgical Plan to be effective beginning January 1, 1957. The response was good, resulting in applications for enrollment by 24 per cent of the number of Blue Cross subscribers to whom the opportunity was made available. The second phase of non-group enrollment, which will consist of enrollment opportunity to all residents of New Jersey who are not presently enrolled in either Hospital Service Plan or Medical-Surgical Plan, is under active study by the Plan.

PHYSICIAN RELATIONS PROGRAM

During the past year, the Plan has continued to improve and expand its program of professional relations. This program is designed to keep all physicians fully informed of Plan procedures and changes which affect the physician in his day to day dealings with the Plan. Beyond that, there is the underlying need to inform physicians of the basic philosophy of Blue Shield and the vital role the doctor plays as a Participating Physician.

The Plan needs the understanding and full participation of all our physicians. The medical profession organized the Plan to help the profession meet its responsibility to provide the people with a degree of economic security against the consequences of illness and disability.

It is essential that the Plan reflect at all times the ideals and purposes of the medical profession. The Professional Relations program not only enables the Plan to keep the profession informed, but also helps the Plan to be responsive to the needs of the profession.

This is accomplished in various ways. The annual supplemental reports to the House of Delegates and the discussion at the open forum are one aspect. Another is the Plan's exhibit at the annual meeting, which in the past has been well attended. Last year, about 300 physicians registered at the Booth and many others stopped to inspect the Exhibit, ask questions, discuss Plan procedures, make suggestions, register complaints. This "give and take" information is carefully reviewed for the purpose of improvement in physician relations, administrative procedures, etc.

A very important aspect of the Professional Relations Program is our field service. Field representatives have been specially trained for this purpose. Under the direction of the medical staff, these workers conduct informative sessions for physicians at community hospitals; they call upon physicians to provide information concerning Plan procedures; they present Plan information before hospital medical staff groups and meetings of doctors' secretaries, and generally assist physicians in their day to day relations with Medical-Surgical Plan patients.

This service has been extended to cover the entire state. During 1956 more than 1200 physicians were interviewed in the course of various exhibits and hospital information sessions at 50 hospitals in 16 counties, at medical society meetings and office visits. Hospital staff groups or local medical societies which desire to have Plan representatives present information and respond to questions concerning Plan policies and procedures are invited to make arrangements through the Plan office.

The entire staff of Medical-Surgical Plan is concerned with professional relations,

whether the aspect be claims review, correspondence, or telephone contact. The Medical Director and his staff welcome all opportunities for conference with representatives of the profession, geographically or by specialty, in order to enhance understanding of the Plan.

The Board of Trustees of Medical-Surgical Plan takes this opportunity to express its appreciation to the Participating Physicians whose steadfast support and cooperation have made possible the continued service and development of the Plan.

The Board also wishes to express its appreciation to Hospital Service Plan of New Jersey for its continued service and cooperation. Finally, a word of gratitude is extended to the staff of Medical-Surgical Plan for loyal and devoted services rendered.

APPENDIX A

MEDICAL-SURGICAL PLAN OF NEW JERSEY
SUMMARY OF OPERATIONS

Year Ended December 31	Earned Subscription Income	Claims Incurred		Operating Cost	Persons Enrolled End of Period
		Amount	% of Income	% of Income	
1942	11,148	5,395	48.4	51.1	4,131
1943	74,498	49,562	66.5	23.9	16,015
1944	187,708	135,605	72.2	18.9	30,427
1945	326,530	208,288	63.7	17.5	49,441
1946	540,227	370,576	68.6	16.8	88,088
1947	947,945	681,922	72.0	17.1	143,700
1948	1,524,814	1,203,651	79.0	15.0	236,604
1949	2,545,518	1,979,542	77.8	13.8	353,827
1950	5,252,060	4,278,098	81.5	12.9	499,882
1951	8,031,305	6,527,374	81.3	10.9	669,906
1952	10,952,158	8,720,257	79.6	10.8	997,303
1953	14,916,204	12,715,442	85.2	9.6	1,183,336
1954	15,864,137	13,991,592	88.2	11.2	1,196,804
1955	17,796,979	15,435,398	86.7	10.1	1,389,965
1956	22,423,453	18,960,672	84.6	9.7	1,546,007

APPENDIX B

REPORT ON PARTICIPATING PHYSICIANS — MEDICAL-SURGICAL PLAN OF N. J.

County	*December* 31, 1955			*December* 31, 1956			% Increase Decrease
	Total Eligible Physicians	P. P.	% P. P.	Total Eligible Physicians	P.P.	% P.P.	
Atlantic	202	172	85.1	204	174	85.3	0.2+
Bergen	709	498	70.2	746	506	67.8	2.4—
Burlington	118	98	83.1	119	99	83.2	0.1+
Camden	379	314	82.8	385	320	83.1	0.3+
Cape May	55	47	85.5	56	49	87.5	2.0+
Cumberland	97	85	87.6	92	84	91.3	3.7+
Essex	1568	1283	81.8	1574	1306	83.0	1.2+
Gloucester	93	72	77.4	88	64	72.7	4.7—
Hudson	709	560	79.0	694	552	79.5	0.5+
Hunterdon	51	45	88.2	48	43	89.6	1.4+
Mercer	371	313	84.4	374	324	86.6	2.2+
Middlesex	290	230	79.3	304	250	82.2	2.9+
Monmouth	308	240	77.9	309	255	82.5	4.6+
Morris	230	185	80.4	243	192	79.0	1.4—
Ocean	68	53	77.9	73	60	82.2	4.3+
Passaic	536	419	78.2	535	412	77.0	1.2—
Salem	51	42	82.4	50	45	90.0	7.6+
Somerset	104	81	77.9	109	93	85.3	7.4+
Sussex	39	30	76.9	38	30	78.9	2.0+
Union	601	419	69.7	609	440	72.2	2.5+
Warren	42	36	85.7	44	38	86.4	0.7+
Total in New Jersey	6621	5222	78.9	6694	5336	79.7	

County Societies • • •

Atlantic

BAXTER H. TIMBERLAKE, M.D., President, Atlantic City

At the annual meeting of the Medical Society of Atlantic County in June 1956, the society honored Dr. David B. Allman, President-elect of the American Medical Association, with a party and dinner. Distinguished guests from the medical and legal profession were present. Included among them was our state President, Dr. Lewis C. Fritts, and Executive Officer, Richard I. Nevin.

The next meeting of the society, held on September 22, 1956, was a joint affair with the Woman's Auxiliary. A reception and dinner party was given in honor of Mrs. David B. Allman, a former President of the Woman's Auxiliary to the American Medical Association, and Dr. David B. Allman. This is the first time in the history of the American Medical Association that a man and wife have been so honored. Nearly 300 guests attended and many prominent persons from Atlantic City and the state of New Jersey attended this affair.

From September 4 to 28, a chest survey was sponsored by our organization and by other public societies. We approved glaucoma and diabetes-detection weeks, which were participated in by members of the society.

Dr. C. H. DeT. Shivers, President of the American Urological Society was honored by the society with the presentation of a plaque at our November meeting. Our society gave complete support and help to the American Public Health Convention held in Atlantic City in November.

At a special meeting December 21, 1956, the society passed a resolution giving approval for the Board of Health of each community to give Salk vaccine in accordance with federal regulations, and offering help when and where needed.

Bergen

WILLIAM T. KNIGHT, M.D., President, Hackensack

Bergen County is continuing to experience a fantastic growth in population. More and more doctors are moving into the county. Within the Society, this growth is reflected in the fact that 53 new applicants were elected to membership. To handle the increasing business of the Society, five new committees have been organized. These are Disputed Medical Bills, Physicians' Welfare and Relief, Special Liaison to the Bar Association, Section Meetings and Highway Safety. In addition, we have re-activated the committee on Venereal Disease and the committee on the Speakers' Bureau. A total of 28 committees have been active during the past 12 months.

From March 1, 1956 to February 28, 1957, we elected 26 doctors to associate membership and advanced 26 from associate to regular status. Nineteen became regular members by transfer from other societies, 2 to regular from courtesy, while 7 were placed on the "emeritus" rolls. Four members were given leave of absence, 5 were reinstated to "regular" from leave of absence and 5 were elected to "courtesy" status. During this period, we lost 14 members, 3 of them by death. Seven resigned and 4 transferred to other societies.

MEETINGS

Our ten meetings during these twelve months covered the following subjects and speakers.

March 1956—Semi-Annual Business Meeting — Election of Delegates—By-Laws changes.

April 1956 — "Current Problems in American Medicine"—Edwin J. Holman, Law Dep't. AMA.

May 1956—"Designing the Medical Office"—Mr. Basil Yurchenko, A.I.A.

June 1956—(Installation Meeting)—Buffet Supper.

September 1956—"Treatment of Diabetes Mellitus"—Dr. Theodore B. VanItallie of Harvard Medical College.

October 1956—Business Meeting.

November 1956—"Recent Developments in Fluid and Electrolyte Management"—Dr. Walter Lawrence, Jr., Center for Cancer.

December 1956—"Medicine and Surgery Behind the Iron Curtain, 1956"—Henry J. Heimlich, M.D., N. Y. Medical College.

January 1957—"Current Trends in Radiology"—Dr. William B. Seaman, Columbia University.

February 1957—"Your Role in The Control of Disasters"—Col. Joseph R. Schaeffer, M.C., Lt. Col. Joseph D. Goldstein, M.C., Walter Reed Institute of Research.

COMMITTEE ACTIVITIES

The ten regular meetings of the Executive Committee of the Society have been attended by a remarkably high proportion of members. Its deliberations have included the following subjects. (All of the Executive Committee's decisions were subsequently ratified by the membership.) We have discussed the creation of a Disputed Medical Compensation Bills Committee, policy on formal society approval of ancilliary groups, policy on recommending non-licensed purveyors of malpractice insurance, major revision of Constitution and By-Laws, a decision against adopting a new classification of membership, adoption of a policy of discontinuing copy from advertisers guilty of non-ethical practices, creation of a new office of Assistant Treasurer, methods of improving the county-wide emergency medical coverage, policy on Salk vaccine distribution problems, approving receptions for legislators and for representatives of the press, a county doctor-clergy dinner, problems arising from fund solicitations for a proposed new osteopathic hospital, methods of improving indoctrination of new members, creation of a special committee on Section Meetings, approval of new office space, cooperation with civil defense-disaster control organization, creation of a special committee on liaison with Fairleigh Dickinson University to explore graduate courses for physicians and establishing our policy on the proposed change in the A.M.A. Ethics Code.

The Public Relations Committee has been unusually active. Under its wing, four public forums have been held. They were:

October 18, 1956—"Overweight—And What You Can Do About It"—Moderator, Dr. Irving Levitas; panelists: Drs. J. Lawrence Evans, Jr., Philip A. Kilbourne, Edward Wolfe and Harry Rhodes, Jr.

October 25, 1956—"Cancer and You—Spotting It Early"—Moderator, Dr. G. Albin Liva; panelists, Drs. Leonard Brown, Vincent Gillson, Eric J. Ryan and Leonard Casser.

February 21, 1957—"Modern Medicine—Miracle and Menace"—Moderator, Dr. George Heller; panelists, Drs. Noel C. Galen, Thomas DeCecio, Samuel B. Reich and William Maurer.

March 7, 1957—"Overweight—Why?"—Moderator, Dr. LeRoy Black; panelists, Drs. Winton H. Johnson, Charles A. Bailey, Abraham Berkow and Alvin Robins.

The forums in October were co-sponsored with the *Bergen Evening Record* and those in February and March with the *Passaic Herald-News*. The four audiences aggregated about 2500 people.

A mail poll of members enlisted a speakers' bureau volunteer list of 80 doctors. These evidenced a willingness to speak in public on a variety of subjects. We will issue a small pamphlet offering organizations in the county the services of a speaker on a medical subject at one of their forthcoming meetings. A list of well over 500 such organizations is on file.

Under the auspices of the Public Relations Committee, two meetings have been held at which the presidents of the Bergen County Medical Society and the Passaic County Medical Society attended, as well as the two chairmen of the Public Relations Committee and members of both societies who reside in Fair Lawn. These meetings were to discuss problems arising from the solicitation of funds from Fair Lawn residents by a group of osteopaths for the erection of a hospital there.

Methods of improving the emergency call system in the county are being developed in the Public Relations Committee with the full cooperation of the many physicians and surgeons telephone exchanges.

BERGEN COMMUNITY BLOOD BANK

The second full year of operation of this blood bank sponsored by this Society shows a large expansion of services. More and more of our communities are establishing town blood banks and through these organizations as well as many smaller local groups, more than a half million of our population are covered in one way or another for blood requirements.

NEXT YEAR

One major problem to be faced by this Society next year is acquisition of a centrally located property on which some day to build our own building. Other problems include the possibility of substituting a limited number of section meetings for general society meetings with the Executive Committee functioning between regular meetings; better indoctrination of new members; increasing the number of members in attendance at regular meetings; and the implementation of the expanded Speakers' Bureau.

Burlington

Richard T. Buckley, M.D., President, Maple Shade

An ambition has been realized in the regular meetings of the Society, namely: to have scientific programs that are instructive and have a wide appeal; and to have business meetings that are concise. This has been successful as evidenced by an average attendance of about 50 per cent of the total membership at every meeting.

The Program Committee under the skilled chairmanship of John R. Wolgamot arranged these attractive meetings.

September 1956: Dr. Richard Cathcart, Jefferson Medical College: "Chronic Pulmonary Disease."

October: Dr. G. A. Rogers, West Jersey Hospital, Camden: "Diagnosis and Treatment of the Alcoholic."

November: Dr. Joseph Langbord, Medical Director of Sidney Hillman Medical Center, Philadelphia: "Industrial Medicine at the Crossroads."

December: Dr. Joseph L. Hollander, University of Pennsylvania: "The Arthridites."

January 1957: Joint meeting with the Burlington County Bar Association at Medford Lakes Lodge, Dr. A. R. Crane, Director of Laboratories, Pennsylvania Hospital.

February: Meeting at Deborah Sanatorium, Browns Mills, Dr. Charles P. Bailey, Hahnemann Medical College: "Cardiovascular Surgery in Modern Medicine."

March: "Home Talent": Drs. Segal, Coburn, and Oppenheimer.

April: "Industrial Toxicology."

May: Joint meeting with the Woman's Auxiliary at Medford Lakes Lodge.

The Executive Committee has held regular meetings, and has done much to make this a successful year. The President thanks the members who have been so faithful and willing to spend time on long discussions of many problems.

The *News Letter* has been a valuable adjunct to the successful function of the Society, and the Journal Committee, with Dr. William E. Bray as chairman, is commended for a very fine work.

The Society has lost a valuable and esteemed member through the death of Dr. Marcus W. Newcomb on January 18. He was a good friend and counsellor.

The following were elected for the year 1957-58:

President—Dr. J. Arthur Steitz
President-elect—Dr. William P. Mulford
Vice-President—Dr. Abraham B. Sand
Secretary—Dr. Winfield Betts
Treasurer—Dr. Robert A. Murphy
Reporter—Dr. Norman K. Boudwin

This has been a successful year, but it would not have been so without the full cooperation of the officers and members. The President is indeed grateful to them, and to the members of the various committees who have served so faithfully. He is especially indebted to our Secretary, Dr. Winfield Betts, for such wonderful help in conducting the affairs of the Society.

Cumberland

Sherman Garrison, Jr., M.D., President, Bridgeton

The Cumberland County Medical Society is gratified to report progress during the year in several fields. Five applicants were elected to membership and two were received as associate members.

We regret the passing of Dr. Hugh Baker of Vineland.

Inter-professional relations were again improved by our attendance as dinner-guests of the Cumberland County Pharmaceutical Association on April 19, 1956. In that month, we presented radio programs which gave a picture of the routine and activities of modern medical schools. A program was conducted by

the staffs of both Newcomb Hospital in Vineland, and Bridgeton Hospital including a panel discussion of various aspects of cancer, by members of the staff.

Our Society was honored by the election of Dr. Albert B. Kump of Bridgeton as President-elect of The Medical Society of New Jersey.

For the first time an advisory committee to the Medical-Surgical Plan and Hospital Service Plan of New Jersey met on October 16, 1956 to review five cases with local hospital official representatives and representatives of the Plans. Evaluation of these cases was made and recommendations were submitted to the Medical-Surgical Plan and Hospital Service Plan. An excellent job was done by this committee, which consisted of Dr. Albert B. Kump, Dr. Benjamin Berkowitz and Dr. Herbert Anastor.

The Diabetes Committee conducted an extensive program this year under the chairmanship of Dr. Sidney Siegel. Dr. Paul Ayars ran a very interesting study from his office in which three unsuspected diabetics were proved out of 97 patients tested.

An excellent job was done by Dr. Paul Ayars, Program Chairman, in providing the following speakers: December 11, 1956—Dr. Edward W. Campbell, Professor of Urology, Hahnemann Medical College "Potential Dangers of Unrecognized and Untreated Urinary Tract Infections in Children:" February 12, 1957—Dr. A. Henry Clagett, Chief of Cardiovascular Section, Memorial Hospital, Wilmington, Delaware "The Management of Coronary Occlusion."

The Society enjoyed the annual outing at Palatine Lake as guests of Owens Illinois Glass Company on June 12, 1956; and were the guests of Seabrook Farms Company on October 9, 1956.

Our public relations continued to improve and I am happy to report that there have been no communications for the Judicial Committee this year.

I extend thanks to the members of the Executive Committee for their cooperation and counsel throughout the year and particularly to Dr. Mary Bacon, whose excellent work as secretary is of incalculable value to the Society. I wish to thank Dr. Siegel and his committee for fine work on the Diabetes Detection Drive, Dr. Samuel Pole for his labors in accounting and auditing the Society funds, Dr. Paul Ayars for his excellent service as Program Chairman, and Dr. Leonard Scott for his fine job of reporting, and to the members of this Society for the privilege of serving them for the past year.

Essex

Marcus H. Greifinger, M.D., President, Newark

The best medical news which I can report for this past year is that one of our New Jersey members became President-elect of the A.M.A. Our County Society was happy to have Dave Allman of Atlantic City address us and our Woman's Auxiliary at our first meeting, last Fall.

Much influential legislation concerning medicine has been enacted during the past year. The "Medicare Program" for servicemen and dependents was put into action locally, by our own Medical Service Administration. Our County Society actively opposed the broadening of certain Social Security Act amendments, and, as you recall, we lost by a slight majority.

PUBLIC RELATIONS

We established the policy of sending a printed card to each newly elected member of our Society, advising him that he is our best medium for public relations. He represents us to the public. We stated that the best public relations will be enjoyed by our profession, if they (1) Discuss all fees with patients before treatment is begun. (2) Be available for service to their patients or leave their practices covered at all times. (3) Attend regularly, the meetings of this society; (4) Take part in deliberation on our business activities and (5) Maintain an ethical relationship with fellow practitioners.

We circularized our Newark members and

set up a larger panel of physicians to take Newark's indigent "City Calls." We now have fifty physicians in this program.

Our Press, Radio, and Television Committee held a luncheon for the editors of all local newspapers and the directors of radio and television stations. We asked how we could be of assistance to them and some practical advice was received concerning local publicity practices and situations.

Stemming directly from this luncheon, we received an invitation to participate in broadcasts by WSOU, the Seton Hall University Radio Station. Our members taped six of these broadcasts for radio presentation in March and April 1957. We hope to have these tapes on a national radio network in the near future.

We were fortunate in recently securing two excellent articles on our County Society health activities. In the February 1957 issue of *Redbook*, a national magazine, we are given credit for initiating a program of annual routine health examinations. For the other article, we set up earphones on our county-wide emergency medical service, and invited a reporter to listen to incoming emergency calls, and how we handled them. His story appeared in *Today's Living*, a special supplement to the *New York Herald Tribune*, on Sunday, December 2, 1956. We, thus enjoyed tri-state coverage (New Jersey, New York, and Connecticut) for a service which we have been paying for these past eight years. A few reprints are available at the Society office

We will co-sponsor a Science Fair in April 1957.

NEW BUILDINGS

1. Our Building Committee investigated a property more centrally located in the county than our present rented office, and advised us to purchase this property and house in East Orange. Our Council favored buying the property, and we obtained an option for $38,-500, pending a vote of our entire membership. This motion to purchase was discussed and defeated at a regular meeting of our Society.

2. Mr. Carl W. Badenhausen of the P. Ballantine & Sons Foundation presented the Essex County Blood Bank with the money to construct a new building. This blood bank building is being donated as a Ballantine Memorial to their employees who gave their lives in World War II. This solves a problem of long standing with our Blood Bank, and we heartily thank Mr. Badenhausen and the P. Ballantine & Sons Foundation for their gift.

FELLOWETTES

Our Society will present pins for the "Fellowettes" of our County Society Woman's Auxiliary. We are proud of our very active Woman's Auxiliary, and happy to honor their past presidents.

SOCIETY SPEAKERS

We had some interesting scientific programs, including one organized by the Veterans Administration Hospital in East Orange. Dr. William T. Fitts, Jr., Associate Professor of Surgery, University of Pennsylvania presented a fine paper on "Cancer of the Breast." Dr. David Lehr, Director, Department of Physiology and Pharmacology, N. Y. College Metropolitan Medical Center, gave a very informative talk on, "Newer Drugs in Medicine and Surgery."

Gloucester

Chester L. Samuelson, M.D., President, Paulsboro

The objectives of our Society for the past year were three in number: (1) To continue the high standards and caliber of the scientific presentation at each meeting; (2) to streamline the business sessions; and (3) To improve relationships and understanding with other groups.

These objectives were accomplished in the following manner: (1) The program committee met early last summer and planned the

program and the activities for the whole year. Subjects were selected which would be of the greatest interest to all members. Competent speakers were obtained to speak on each subject and the dates of such speakers were confirmed. When the announcement of the first meeting last fall was sent out, the program for the whole year was printed in our first *Bulletin.* (2) Members were asked to submit any business to be presented to the proper committee first. The committee then took the matter under advisement, and at the business session of each meeting, presented it in an orderly manner with the studies that had been made and specific recommendations for action. The membership cooperated wholeheartedly and our business sessions have been short and to the point. (3) Three meetings were set aside as joint meetings. "Medical-Legal Aspects of the Practice of Medicine" was the subject of one meeting. Our guests were members of the Gloucester County Bar Association. The presentation was well accepted by both groups and we feel that we now have a much better understanding and working arrangement with the local Bar Association as a result of this meeting. Our March meeting was on "Oral Lesions." The dentists of Gloucester County were our guests. The last meeting of the year was devoted to Public Relations. This was a joint meeting with the Gloucester County Woman's Auxiliary.

These joint meetings have been so successful that we understand for the coming year, we, in turn, will be asked to be guests of some of the local societies again on subjects of joint interest.

Hudson

John E. Annitto, M.D., President, Jersey City

Regular monthly meetings, focal point of the Society's activities, have been fairly well attended. We are indebted to Dr. Robert Rubenstein and his committee for providing guest speakers of the high caliber of Drs. Saul Krugman, Charles L. Fox, Jr., Robert L. Rosenthal, Henry Doubilet, and John S. LaDue, all of New York City, and Dr. Harold Jeghers, director of the Department of Medicine, Seton Hall College of Medicine and Dentistry.

Functioning zealously throughout the year have been several standing and special committees. While a detailed account of their endeavors must be curtailed for lack of space, mention at least must be made of a few. The *Judicial Committee,* under the exceptionally able chairmanship of Dr. A. P. Rieman, is continuing to perform an outstandingly fine service, both to the Society and to those who appeal to the Society for assistance. Under the leadership of Dr. C. B. Blasi, the *Diabetes Committee* sponsored a successful Diabetes Detection Drive during November. The *Emergency and Night Service Committee,* of which Dr. A. D. Casciano is chairman, has exercised the necessary vigilance during the past year to maintain a generally satisfactory system.

Drs. Saradarian and Amdur, with other members of the *Committee for the Conservation of Sight* have worked effectively toward the accomplishment of important objectives. The *Advisory Committee to Selective Service,* under the chairmanship of Dr. C. M. Bahnson, has functioned smoothly and efficiently. In connection with the *Bulletin,* on which we receive many compliments, mention must be made of the chairman of the *Publication Committee,* Dr. H. B. Schwartz; the editor, Dr. C. A. Landshof; and the associate editor, Miss Agnes G. Sinnott. Then, too, the services of the *Committee on Constitution and By-Laws* have been rendered willingly and competently.

The *Executive Committee,* of which I have the honor to be chairman, has met regularly and has devoted considerable time and effort to the diverse problems that have arisen within the Society and profession within the past year.

The Society records with deep regret the death of eight members—Drs. Oscar Jacks, William M. Doody, Henry J. Lease, James A. Wheeler, G. Irving Levine, I. Harold Franklin, Albert A. Mutter, and today — Dr. John B. Faison. Offsetting this loss, we have welcomed thirteen new members. At this time, we have but one member in military service, Dr. Alfred J. Swyer.

The Society continues its group plan in *Hospital Service Plan of New Jersey,* conducting two enrollment periods during the year, and having a total of two hundred thirty subscribers.

In this report of the year 1956-57, we take pleasure in recording an event of extraordinary medical significance—the opening, on September 17, 1956, of the first medical college in New Jersey—Seton Hall College of Medicine and Dentistry, in Jersey City.

The Society's single social event of the year, under the chairmanship of Dr. Harold Gorenberg, took place on March 2, when our members and their wives assembled at the Hotel Essex House in Newark for the Third Annual Dinner-Dance in honor of the president—who is truly grateful for this fine tribute.

Mercer

Jacob M. Schildkraut, M.D., President, Trenton

Dr. Ralph N. Cagan, Chairman of the Program Committee assisted by Drs. Sherwood Vine, Stanley B. Apple, and Francis P. Henry, are to be complimented on arranging the outstanding scientific sessions. Thus, Dr. Karl Paschkis, Director, Endocrine Research, Jefferson Medical College, spoke on: "Newer Concepts in Thyroid Diagnosis and Management."

Our January 9 meeting was held at the Trenton State Hospital, as guests of Dr. Harold S. Magee, Superintendent, and his staff. Dr. Magee is a past-president of Mercer Society. Dr. Jacob M. Schildkraut, President, introduced Dr. Magee.

The program was in two phases: "The Use of Ataractic Drugs" and "Case Presentations." Following each discussion the patient was presented to the assembled group for evaluation of the efficacy of the ataractic drugs. At the conclusion of the program a question and answer session was held, and members of the society were privileged to direct questions to members of the hospital staff.

A social hour followed the regular meeting.

For our March meeting, Dr. Cagan and his committee secured Dr. Thomas Johnson, Professor of Gastroenterology, University of Pennsylvania, whose subject was "Pitfalls in the Diagnosis of Small Bowel Obstruction."

The fifth series of the radio program, "Help Yourself to Health," was presented each Monday evening (November 13, 1956 through February 25, 1957).

Dr. Meyer H. Friedman and the members of our Public Relations Committee, in cooperation with members of the Mercer County Component Medical Society; the Woman's Auxiliary to the Mercer County Component Medical Society; radio station WBUD; Mrs. Nan Rednor ("Nan About Town") who served as Moderator; representatives of the press; Mercer County Pharmaceutical Association; New Jersey State School for the Deaf; General Motors Corporation; McKinley Hospital Clinic; Alcoholics Anonymous; Mr. William B. Meytrott, Superintendent of McKinley Hospital; Dr. L. Samuel Sica, of St. Francis Hospital; and Miss Sara Harrison, Supervisor of Nurses, Mercer Hospital were responsible for a highly successful program.

At a special meeting, May 28, 1956, at which 124 members were present, the Mercer County Medical Society voted to approve the administration of Salk vaccine in the schools. The professional teams were formed about a nucleus of school and city physicians. Other physicians rendered their services on a voluntary basis. In this manner, the first and second injections were administered to 9,000 children of school age.

The Mercer County Medical Society has taken cognizance of the decisions and suggestions of the Board of Trustees of The Medical Society of New Jersey and the Blood Bank Commission. The Blood Bank Committee of our organization is now making preliminary studies in an effort to conform to those patterns.

The Cancer Committee, of which Dr. John F. Johnson is Chairman, cooperated wholeheartedly with the Community Health Program on radio and in the larger shopping centers and is preparing a program for industry, similar to previous years.

The Tumor Clinics in the three larger hospitals have been adequately staffed by members of Mercer Society.

Our President, Dr. Jacob M. Schildkraut, will be the Chairman of the Mercer County Chapter of the American Cancer Society.

Under the chairmanship of Dr. Raymond E. Miller, the Mercer County Medical Society, last November, participated in the observance of the "New Jersey Diabetes Detection Drive" in cooperation with the New Jersey Department of Health; the Woman's Auxiliary of The Medical Society of New Jersey; and many other agencies. Among the features of the drive was the distribution of pamphlets entitled "50,000 Citizens of New Jersey have Diabetes and Don't Know it—Are You One of Them?"

The buffet luncheons served after each meeting by members of the Woman's Auxiliary continue to stimulate attendance.

The proceeds of the annual Nurses' Scholarship Dance, sponsored by the Woman's Auxiliary, were applied to the Nurses' Scholarship Fund.

Dr. David B. Allman, President-elect of the American Medical Association, and Dr. Charles L. Brown, Dean of Medicine, Seton Hall College, were the guest speakers at Mercer County Society's annual banquet, December 5, 1956, at the Trenton Country Club.

The past president's plaque was presented to Dr. Albert F. Moriconi (1955-1956) by President Jacob M. Schildkraut at the banquet.

Dr. Enoch Blackwell and Dr. Paul B. Means were elected to emeritus membership.

Members of the Mercer County Pharmaceutical Association were our guests at the annual outing at the Trenton Country Club, June 14, 1956.

On February 13, 1957, the following were elected to offices for the year 1957-58:

President—Dr. James A. Fessler, Sr.
Vice-President—Dr. Samuel J. Lloyd
Secretary-Reporter—Dr. Walter R. Edwards
Treasurer—Dr. William E. Mountford

Middlesex

Sydney D. Becker, M.D., President, Keyport

In January 1956, Dr. Norman Rosenberg spoke on the treatment of mass casualties. Dr. Rosenberg is county medical coordinator for civil defense. Other speakers on this program included Mr. L. W. Livingston, Mr. A. Eckert and Dr. John Henderson.

The February meeting heard Dr. Richard A. Bader of New York talk on pulmonary insufficiency. In March, Dr. T. P. Almy of Cornell spoke on duodenal ulcer. Cornell also supplied the speaker for our April meeting—Dr. Victor F. Marshall, whose topic was pyuria in infancy and childhood.

In May we had our usual outing and in June our annual meeting. Dr. A. L. Lapp gave an unusual talk at that session, speaking on "The World of Tomorrow." Dr. Lapp is director of Nuclear Science Service.

After the summer recess, we heard Dr. Burril Crohn speak, in October, on colitis and ileitis. In November, Professor Garfield Duncan of the Jefferson Medical College presided at a session on diabetes. Our last 1956 speaker was Dr. Arthur Patek of Columbia University who talked on liver function tests.

Monmouth

John W. Hardy, M.D., President, Neptune

Salk vaccine is the first item that comes to mind in reviewing the past year's activities of the Monmouth County Medical Society. This subject was discussed and rediscussed at the regular society meetings and also at committee level.

The schedule of seven regional clinics inaugurated in cooperation with allied health agencies of the county on February 1, 1955 for the administration of the vaccine to those unable to pay and those unable to obtain the vaccine from their physicians came to a close

on October 31, 1956. During this nine-month period, the clinics, strategically located throughout the county, conducted 112 clinic sessions (16 at each location) and administered 20,993 inoculations; of these, 11,212 were first and 9,181 were second injections. It is planned to reactivate the regional clinics during May for the administration of third injections to those who previously received the vaccine at the clinics.

Our Public Relations Committee through the use of display placards in physicians' offices and news releases and advertisements are emphasizing the importance of all children and adults receiving Salk vaccine.

We are pleased to note that four of our members have passed the half-century mark in the practice of medicine and surgery as follows:

Harry W. Ingling, M.D., Freehold (57 years)
Harry B. Slocum, M.D., Long Branch (55 years)
Julius A. Toren, M.D., Oceanport (50 years)
R. Browning Wilson, M.D., Red Bank (59 years)

A series of scientific programs covering a wide field of interests has been presented by our Program Committee. An innovation this year has been a program schedule to provide for a business meeting of the Society on alternate months and a combined scientific and business meeting for the other months. This allows the opportunity for more detailed discussion of Society affiairs by the entire membership.

In addition, we continued the practice started several years ago of holding one of our regular monthly meetings at the U. S. Army Hospital, Fort Monmouth, and for the sixth consecutive year held a joint dinner meeting with the Dental and Pharmaceutical Societies. Our Society has accepted the invitation of the local Bar Association to attend their March meeting and view the A.M.A. film, "The Medical Witness."

Five projects worthy of particular note are presently being investigated at committee level: (1) periodic physical examinations for our membership; (2) the creation of a welfare fund for needy members and their families; (3) the formation of a liaison committee to the County Bar Association; (4) an adequate blood procurement program; and (5) a uniform schedule of school physicians' duties.

Our Woman's Auxiliary demonstrated its usual enthusiasm and willingness to cooperate with the Society and was responsible for two very successful affairs, the annual summer and winter dinner-dances.

The various Public Health Subcommittees were active in their specific fields in maintaining liaison with lay health agencies and participating in the programs of those agencies.

It would be rather difficult to describe in detail all committee activities — other committees than those mentioned have accepted assignments and fulfilled their function when called upon.

The opportunity is taken to record my appreciation of the cooperation and assistance extended me by the Executive Committee, the membership of the Society, and the Executive Secretary throughout the year.

Morris

George L. Nicoll, M.D., President, Dover

The fiscal year of the Morris County Medical Society began with the annual meeting on June 31, 1956, at the Spring Brook Country Club. There was a good turnout for the golf tournament in the afternoon. A fine assortment of prizes were awarded to the winners. At the dinner meeting in the evening we were honored by the presence of several distinguished guests from The Medical Society of New Jersey, including Dr. Lewis C. Fritts, President, Dr. Vincent Butler, the immediate Past President and Mr. Richard I. Nevin, the Executive Officer.

Subsequent meetings held in the Warner Chilcott Laboratories in Morris Plains have been well attended and the programs have been of the highest caliber, with such outstanding speakers as Lt. Col. Joseph D. Goldstein of Washington, D. C., Dr. Max Chamlin, Professor of Ophthalmology at Albert Einstein Medical College and Dr. Ralph Deterling of Columbia Presbyterian Hospital, New York City.

At the January dinner meeting we were privileged to renew old acquaintances and make new friends among the members of the Morris County Bar Association. These joint meetings with various other professional and

business groups in the county are good for public relations and we look forward to them each year.

Our membership continues to grow so that at the Annual State Meeting in 1957 we will be represented by 16 delegates. Two new life members have been added to the already distinguished list of doctors who have practiced medicine in the county for 35 years: they are Dr. Ray Matthews of Morristown and Dr. Thomas S. Thomas, Jr., of Morristown.

To have component members of our county society continue to take an active part in promoting good medicine at the community level is a challenge which the various communities continue to work on. The television program "Medical Horizons" which emanated from Morristown Memorial Hospital in December, 1956, was well received by the communities in the county.

It has been a real privilege and honor to have served as president this year. My sincere thanks go to the members of the Executive Committee who met regularly and worked untiringly to further the interest of the County Society.

Finally, none of these activities would have gone so smoothly if it were not for the quiet but efficient presence of the executive secretary, the one and only Miss Janet Clark.

Passaic

Abraham Shulman, M.D., President, Paterson

Particular efforts of the Passaic County Medical Society during the past year have been devoted to improving public relations. We continued our Annual Press Dinner at which the Welfare Council and the Public Relations Committee meet informally with the representatives of the newspapers of our county. This meeting is always a fruitful one, productive of really good results. As we meet each year, the newspapers achieve a better understanding of medicine and its problems, and we achieve a better understanding of the functions of newspapers and *their* problems.

Along the same line, we have, in association with the Passaic *Herald-News*, continued to sponsor medical forums. This year's forums were entitled "A Child is Born" and "What Your Eyes Tell Your Physician." These forums help in giving authoritative information to the public. The *Herald-News* deserves a great deal of commendation for its work in this field.

In other areas of activity, things have gone on much as before. Our scientific meetings are well attended because the Program Committee pays attention to its job, gets worthwhile speakers on worthwhile subjects, and offers diverse programs during the year.

The County Society has become interested in a broad program of Salk vaccine inoculations, and (in association with the National Foundation for Infantile Paralysis) the Passaic County chapter intends to make an intensive campaign to get every resident under the age of 40 inoculated.

The Medical Society Building is in good financial shape. It is occupied by the Executive Office of the Society, the Medical-Dental Service Bureau, and the offices of the Passaic County Chapter of the American Cancer Society. The Woman's Auxiliary also has its office here, and its work with the Homemaker Service has been of great help to many of our patients. The meeting room is used by various health groups and agencies, as well as the occupants of the building.

The financial audit for the fiscal year ending May 31, 1956 showed the Society to be on a sound fiscal basis in all its activities.

I want to thank Miss Cornelia Horn, our Executive Secretary, for her devoted interest in the office of the Society, and also thank her associate, Mrs. Lorraine Mirandon, for her good efforts. The many details entailed in the daily management of our affairs are astonishing. Members have no realization of how much time and effort are required of our office personnel in answering inquiries from, and providing information to, the general public on health questions, doctors, locations, availability of specialists, as well as many questions not always relevant to the activities of the Society.

I thank my fellow officers for all their support through the year. They have been extremely helpful. And I especially thank Mr. Randall Norris for all the help and cooperation that he has given the officers and committees of our Society.

Salem

Isador Lipkin, M.D., President, Penns Grove

During the fall of 1956, nearly all the members of the Salem County Medical Society joined the Hospital Service Plan of New Jersey through the society. This forward step in our individual health and our collective support of New Jersey's own Blue Cross Plan was organized through the society's newly elected treasurer, Dr. George Nitshe. Three new members were elected and one left to enter residency training.

The largest problem met by the society this year was the development of a comprehensive program to insure full utilization of the Salk vaccine. A special committee under Dr. Harry W. Fullerton, Jr., was appointed to study the problem. Releases were issued to the local newspapers urging everyone to be vaccinated in the office of the physician of his choice. So few took advantage of the opportunity, that the committee decided to permit the participation of member physicians in the clinics which had been scheduled by various municipalities and school districts in the county. The society announced in news releases and by paid advertisements that its members would not expect to participate in any such clinics after June 30, 1957. It is hoped that these two steps will encourge the public to seek Salk vaccination this Spring.

Union

Paul J. Kreutz, M.D., President, Elizabeth

We began our new season of 1956-1957 with a party in Atlantic City in honor of Mrs. Bertram J. L. Sauerbrunn, newly elected President of the Woman's Auxiliary to The Medical Society of New Jersey. Mrs. Sauerbrunn was President of the Woman's Auxiliary to the Union County Medical Society in 1949-1951. It was a most enjoyable affair and there were many guests besides the members of the County Society and the Woman's Auxiliary.

The annual outing was held at Echo Lake Country Club in Westfield with the usual large number of members present. Golf and fishing were enjoyed and dinner in the evening was attended by several guests. It was the last time we had the pleasure of having Mrs. Florence P. Dwyer as a member of the State Assembly for, as everybody knows, she is now Congresswoman Dwyer.

The Woman's Auxiliary is as always our right hand and this year has undertaken the project of assisting the State Society in getting our members to fill out the new biographic sketches and return them as quickly as possible. Their activities have been many and varied and the ever increasing membership shows their interest in all matters that help maintain the high standards of their husbands' profession. When Mrs. Sauerbrunn was President of the county auxiliary their membership was 165; today it is 256.

This past year our Society sustained the largest loss of membership by death than in many years. Eleven of our members died, four of whom were emeritus members and the youngest was an associate member in practice only two months. Two members resigned and nine transferred to other counties or states. Our present membership at this time is 512 active members, 39 associates, 1 in military service, 4 residents and 13 emeritus members, making a total membership of 569.

The Indoctrination Program as a whole is working very well and because the associate members are responsible for all emergency calls, our service has been greatly improved in getting a physician to the patient more quickly.

There are many new housing developments in our county, and we are receiving many calls from one of the towns over the county line because there is only one doctor there and the County Society has no office or emergency service. With the consent of our members we take care of as many of those calls that we can as a patient's illness is the first consideration.

The Indoctrination Committee held its first

meeting in October with the new members and it was most successful. Twenty-seven of the 37 associate members were present. Many of them were for the first time really aware of the functions of the American Medical Association and the service that they can receive as members. The functions of the State Society were fully explained as were the County Society. The duties of a member to his Society and the assistance that the Society can give the new practicing physician were clarified. The next meeting will be held on March 10, and the guest speaker will be an outstanding lawyer in the state who will explain many phases of malpractice and medical-legal problems. One of our members who is very familiar with many insurance problems relating to the medical profession will also participate. These are the two meetings for the year as all associate members are required to attend two of four meetings during the two years of their associateship.

The Indoctrination Program has also been most helpful to the Executive Office staff as they have the opportunity to meet the members when they apply for membership and get to know them. The doctors call or come to the office for assistance and information on many matters such as: part time medical positions available, accident and health insurance, Blue Cross, personnel, homemaker service, nurses, clinics, various types of organizations to help with patient problems, requests on background of physicians who referred patients or to whom they wish to refer patients, telephone listings, newspaper advertising, and many other matters.

Our annual press dinner attendance is growing each year and we find many points of mutual interest to discuss. We feel that our press relationships with our county newspapers are most cordial and cooperative.

We have continued to hold our meetings at White Laboratories in Kenilworth which is the center of the county and is very convenient for our members. Attendance averages about 15 per cent of the membership. The younger members are very interested and active in the affairs of the Society. Several have sustained very high attendance records over a period of five years.

The Public Relations Committee presented recommendations for telephone listings and newspaper publicity which were approved. This new procedure has been most helpful to the members since it became official.

With the new equipment purchased this year, the executive staff is finding it most helpful and timesaving. We still need larger headquarters particularly with the large equipment taking up space that is needed when committee meetings are held in the office.

The demands on our office for referrals are growing every year as so many new residents are moving into our area. The calls are not only from our county but other counties and states as well. In the past year we have received over a thousand requests for names of physicians either general practitioners or specialists. We always ask if the patient has a family doctor first and if they do not we give them four to six names in their home area so that they might choose one. We have given 3791 names of members to patients. We receive the calls not only from patients but members who have had patients referred to them and they wish to know something about the medical background of the physician. Sometimes patients move away and the family doctor, or specialist, wishes to refer them to qualified physicians to continue the proper treatment and care that the patient received here.

Dr. Max Shapiro and the members of the Diabetes Committee did outstanding work on the Diabetes Detection Drive with very fine results.

The Judicial Committee reviewed several cases which were concluded satisfactorily without having to be referred to the State Committee. The Committee will be in charge of our May program. It has been several years since the Committee presented a program and it should be most informative and instructive. The Committee not only passes on the eligibility of applicants for membership but from time to time reviews the report cards kept on the associate members. These report cards will be presented to the Committee for their approval before the associate member can be elected to active membership at the end of the two-year associateship.

The various committees of the Society have proved their readiness and willingness to serve when called upon. I am particularly grateful to the members of the Executive Committee for their excellent attendance at the regular meetings and their interest and cooperation in solving the various problems presented to the Society.

Announcements • • •

Medical Trips to Europe

A.M.A. members who attend the annual session in New York June 3 to 7, have the opportunity of taking European trips arranged in cooperation with the World Medical Association. There is also available a post-session trip to Bermuda. For more details about these trips write to William J. Glennon, P. O. Box 3433, Chicago 54, Ill.

Obstetric-Gynecologic Meeting

While coming to Atlantic City for the Annual Meeting of The Medical Society of New Jersey, you are also invited to attend a District Session of the American College of Obstetricians and Gynecologists at The Traymore Hotel in Atlantic City, on April 27.

The Third District of the American College of Obstetricians and Gynecologists comprises Pennsylvania, Delaware, and New Jersey, and the entire program is being conducted by personnel from these three States.

Board of Obstetrics and Gynecology

Applications for certification by the American Board of Obstetrics and Gynecology (new and reopened) for the 1958 Part 1 Examinations are now being accepted. Deadline for receipt of applications is September 1, 1957. No applications are accepted after that date.

Candidates for admission to the Examinations are required to submit with their application, a typewritten list of all patients admitted to the hospitals where they practice, for the year preceding their application. This information is to be attested to by the Record Librarian of the hospital and submitted on paper 8½x11". Necessary detail to be contained in the list of admissions is outlined in the Bulletin and must be followed closely. Obtain more details from American Board of Obstetrics and Gynecology, 2105 Adelbert Road, Cleveland 6, Ohio.

Course in Hypertension

On June 26 and June 27 a full-time, 2-day course will be given on the management of hypertension. This is scheduled for New York City and details may be obtained by writing to the Dean, New York University, 550 First Avenue, New York 16, N. Y. This course, directed by Dr. J. Marion Bryant, will be concerned with the presentation and demonstration of etiologic theories, emotional factors, the natural course, relative significance of blood pressure levels, eye grounds, cardiac silhouette, electrocardiogram, renal function, significance of obesity and arteriosclerosis, and unilateral renal disease. Emphasis is placed on hypotensive drugs, sympathectomy, nephrectomy, and diet-therapy.

Physical Therapy Meeting

From September 9 to 13, clinical and scientific programs will feature the American Congress of Physical Therapy. This parliament of physiatry meets in Los Angeles. For more details write to Miss Dorothea Augustin, American Congress of Physical Therapy, 30 North Michigan Ave., Chicago 2, Illinois.

Did You Ever Hunt Pheasants?

The medical meeting sponsored by the South Dakota Medical Association will be held at Mitchell, South Dakota, during the first five days of pheasant hunting season, October 1957.

The program will feature morning scientific sessions, afternoon hunting and evening social sessions. The $100 registration fee will cover the out-of-state hunters' license, guides, reserved hunting areas, several social events, and the scientific program. Motel and hotel space has been reserved, but registration is limited to the available housing.

The affair is not stag, but wives and other ladies who hunt must pay the full registration fee and those not hunting, three-fourths of it. Interested? Write to South Dakota Medical Association, First National Bank Building, Sioux Falls, S.D.

TUBERCULOSIS Abstracts

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Vol. XXX April, 1957 No. 4

Food for the Upper Age Group and Nutritional Implications

By Esther L. Batchelder, Ph.D., American Journal of Public Health, October, 1956.

Information about foods eaten by older people, in relation to their nutritional status, has been coming recently from regional research conducted cooperatively by Western and North Central groups of Experiment Stations and the Human Nutrition Research Branch of the Agricultural Research Service. Studies have been published giving information on people in California, Iowa, Michigan, Missouri, Nebraska, South Dakota and Wisconsin. The Public Health Service and state and local health agencies cooperated actively in the California studies.

The people studied were "well" rather than "sick" people; they ranged in age from 30 to over 90 years; and their food intakes, except for one group, represent those of people managing their own affairs and buying foods and services. Their choices were undoubtedly influenced by levels of income, intelligence, education, experience, habits and market offerings.

Calcium—and Milk

Women collaborating in a coordinated metabolic study in five of the North Central states showed the highest average calcium intakes. This group met the National Research Council's allowances, except for the women 70 years or older, whose average fell somewhat below. About one-seventh of them were of low but not indigent economic level, about three-fifths were comfortably situated as to buying power, and the remainder were of upper socioeconomic status. It seems reasonable to look upon the relatively high average intakes of this group as representing choices of people who could afford to buy milk products and other sources of calcium if they desired.

Women selected, by means of area sampling, as representative of all women 30 years old and over in Iowa and South Dakota, reported diets which for each age decade were considerably lower than the NRC allowances for calcium. A U. S. Department of Agriculture study of homemakers in three cities showed averages similar to the Iowa and South Dakota figures.

To sum up the calcium studies: women representing a cross-section of two midwestern states and three large cities ate on the average, during a 24-hour period, far less calcium than the National Research Council allowances and reported very low intakes of milk. The North Central women collaborating in the metabolic study showed a relatively high average intake, but contained individuals with calcium intakes far below recommended levels.

These findings provide good reasons for public health workers, community nutritionists, teachers, and other leaders to encourage higher calcium intakes. There seems also to be good nutritional, as well as business reasons, for producers and processors of calcium-rich foods, notably milk and cheese, to seek ways of improving products and increasing sales. Products such as nonfat milk solids in the new fast-dissolving forms are convenient and economical.

Vitamin C—Fruits and Vegetables

Men and women living in their own homes in San Mateo County, California recorded average intakes of food supplying considerably more vitamin C, or ascorbic acid than the National Research Council allowance. However, men over 60

• Nutrition in the upper age groups has been the subject of intensive research in many parts of the country. The findings shed light on the health problems of this group among which tuberculosis is of increasing importance.

in the San Mateo County Home had low intakes. Intakes of the women in South Dakota which were somewhat below the allowance for ascorbic acid in all age decades, after 70 years of age averaged only half the recommended intake. The levels for women in the Midwest, South and Northeast averaged 10 per cent below the allowance.

Availability of citrus fruits and other rich sources of vitamin C on the West Coast would appear to have been a factor in the relatively high average intakes of men and women living at home. Even in California, the institutional diet was low in vitamin C.

The data from South Dakota indicated that more than half the ascorbic acid came from vitamin-rich vegetables and fruits and almost one-third from potatoes. About one-tenth came from other fruits and vegetables. Within the vitamin-rich fruit group, tomatoes were included and were used as much as any other single fruit; peaches came next, followed by oranges, grapefruit and berries. Among the San Mateo County subjects there was a definite relationship between serum ascorbic acid levels and vitamin C intakes and also between the serum levels and lack of teeth or gingivitis. In San Mateo County, serum ascorbic levels were lowest for those in the low economic group—the men in the County Home. The people on relief and assistance rolls were somewhat higher, those of the middle income group still higher, and those of the highest income level had the highest serum ascorbic acid levels.

To sum up the vitamin C findings; keeping the serum ascorbic acid high may save teeth. The low levels of intake observed in many parts of the country make it appear that foods rich in vitamin C need to be made more attractive to adults. Availability, cost, convenience are all factors to be explored. Frozen and dried citrus concentrates and other dependable year-round sources of vitamin C may deserve more attention.

Food Intake Patterns

The frequency of designated food groups in the 24-hour intakes was reported by women in the low sample. More than 90 per cent of the women had eaten fats; bread or other cereal products; meat, poultry, or fish. From 70 to 89 per cent had eaten white potatoes and desserts other than fruit. From 50 to 70 per cent had eaten vitamin-rich vegetables and fruits; other vegetables; eggs, cheese, and legumes; and fluid milk. Less than half had had other fruits. The most popular kinds of foods among the Iowa women were fat, bread, meat, potato, and desserts other than fruit.

In the South Dakota sample 60 per cent of the desserts were "made"—with cakes leading in popularity, cookies and pies next. Total fat in the South Dakota diets was estimated at 40 per cent of the calories, 19 per cent coming from table fats. Whereas there was a decrease of average energy intake with age, there was no consistent drop in the percentage of total calories from major food groups. Sweets and desserts, then cereal products, then table fats accounted for more than 60 per cent of the calories. The popularity of high calorie foods should be considered as nutrition workers attempt to suggest ways to prevent and control overweight through diet.

Overweight has sometimes seemed associated in individual cases with unexpectedly low values for recorded or recalled food intakes. It is often suggested that the low values are actually underestimates (conscious or subconscious) of the actual food eaten. Perhaps where underestimations are reported it is in the quantities assumed as normal servings by the scientists calculating the nutritive value of the diet. For nutritional evaluation of diets the amounts of food must be known. One part of the North Central project was directed toward establishing characteristic sizes of servings through determining the weights of foods eaten. After age 70 decreases were apparent in most portion averages. However, the amounts of sugar and cream added to beverages and the amounts of table fat used increased after the age of 50.

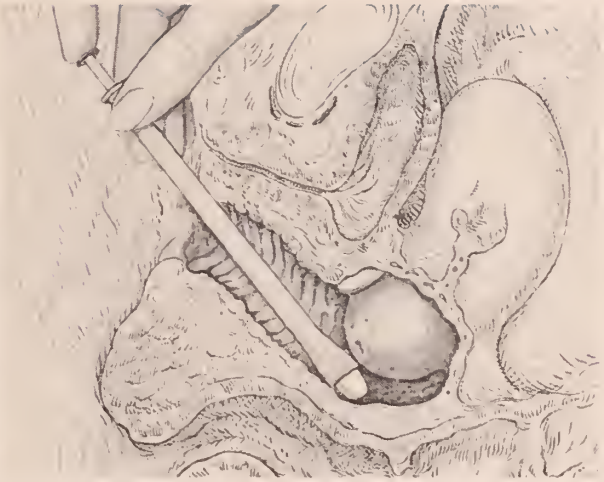
For research workers the findings from these studies provide additional tools for evaluating dietary data, for improving methodology, and for planning new research. For community nutritionists and teachers the information would seem to provide support for continued emphasis on milk and vitamin-rich fruits and vegetables as food sources of nutrients. The data made available should interest those concerned with various aspects of food processing, food service, and food habits.

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*Williamson, P.: Trichomonad Infestation, M. Times *84*:929 (Sept.) 1956.

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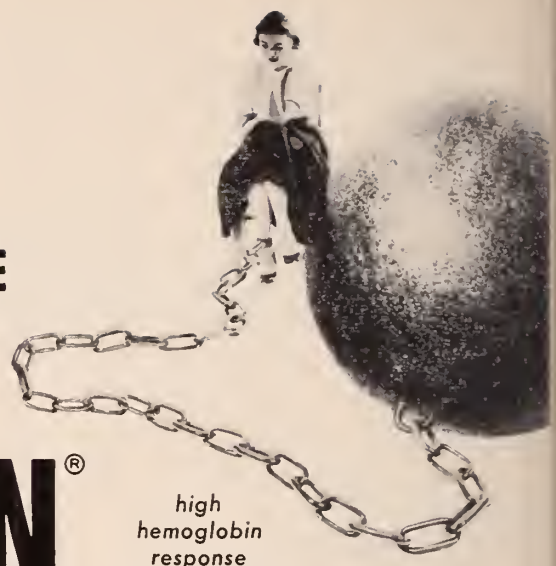
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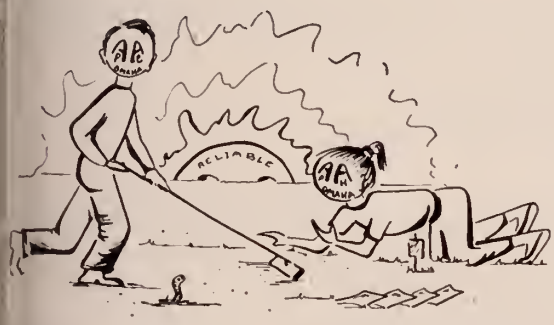
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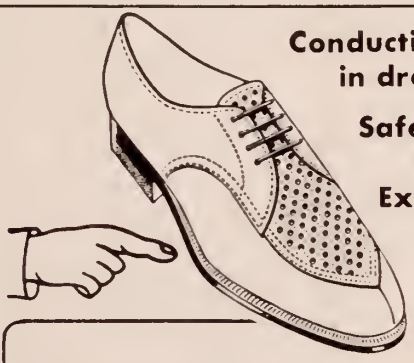
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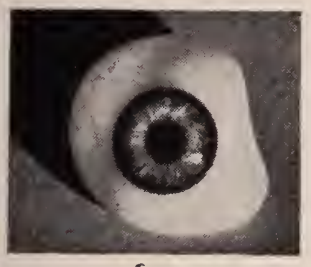
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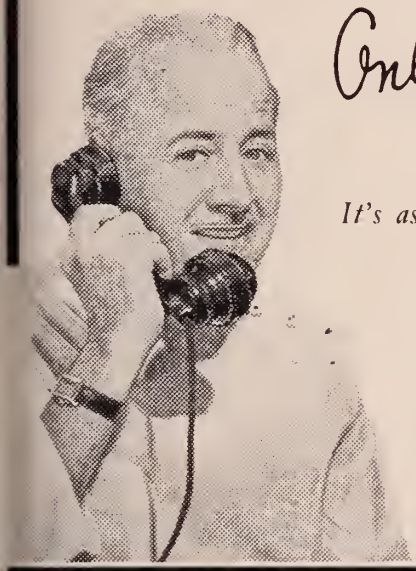
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SOME EMOTIONAL ASPECTS OF THE ANGINAL SYNDROME Alvin P. Shapiro, M.D., Department of Clinical Science, University of Pittsburgh

MEDICAL TREATMENT OF THE ANGINAL SYNDROME — Paul David, M.D., Director, Montreal Institute of Cardiology

SURGICAL MANAGEMENT OF THE ANGINAL SYNDROME Arthur M. Vineberg, M.D., Director, Cardiac Surgery, Royal Victoria Hospital, Montreal

General Discussion

" PULMONARY EDEMA"

2:00 P.M.

presiding

GEORGE D. GECKELER, M.D., President-elect, Heart Association of Southeastern Pennsylvania

DIFFERENTIAL DIAGNOSIS John S. LaDue, M.D., Ph.D., Assistant Professor of Medicine, Cornell University

EMOTIONAL ASPECTS IN PATHOGENESIS — Morton F. Reiser, M.D., Associate Professor of Psychiatry, Albert Einstein College of Medicine

PATHOLOGIC PHYSIOLOGY OF PULMONARY EDEMA — S. J. Farber, M.D., New York University College of Medicine

TREATMENT OF PULMONARY EDEMA Arthur C. DeGraff, M.D., Samuel A. Brown Professor of Therapeutics, New York University College of Medicine

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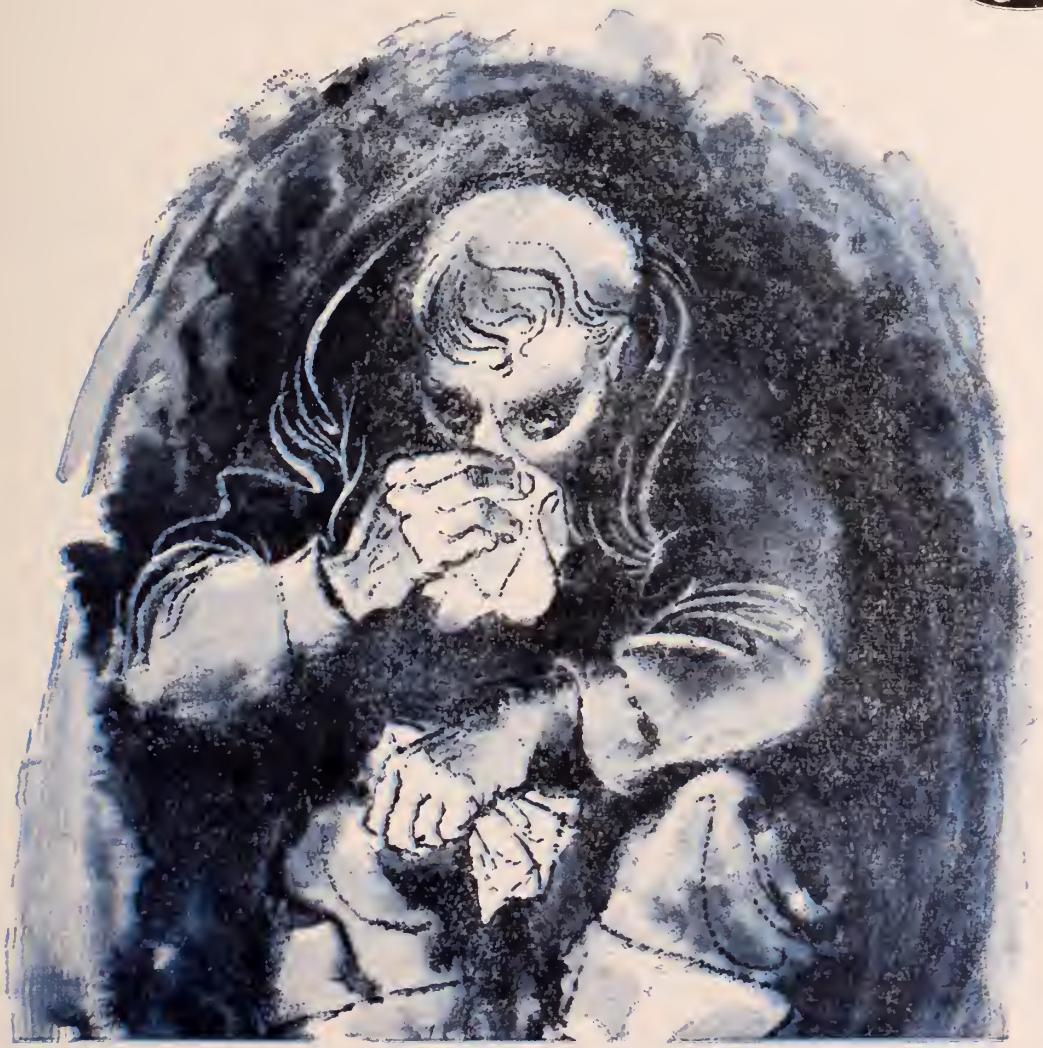
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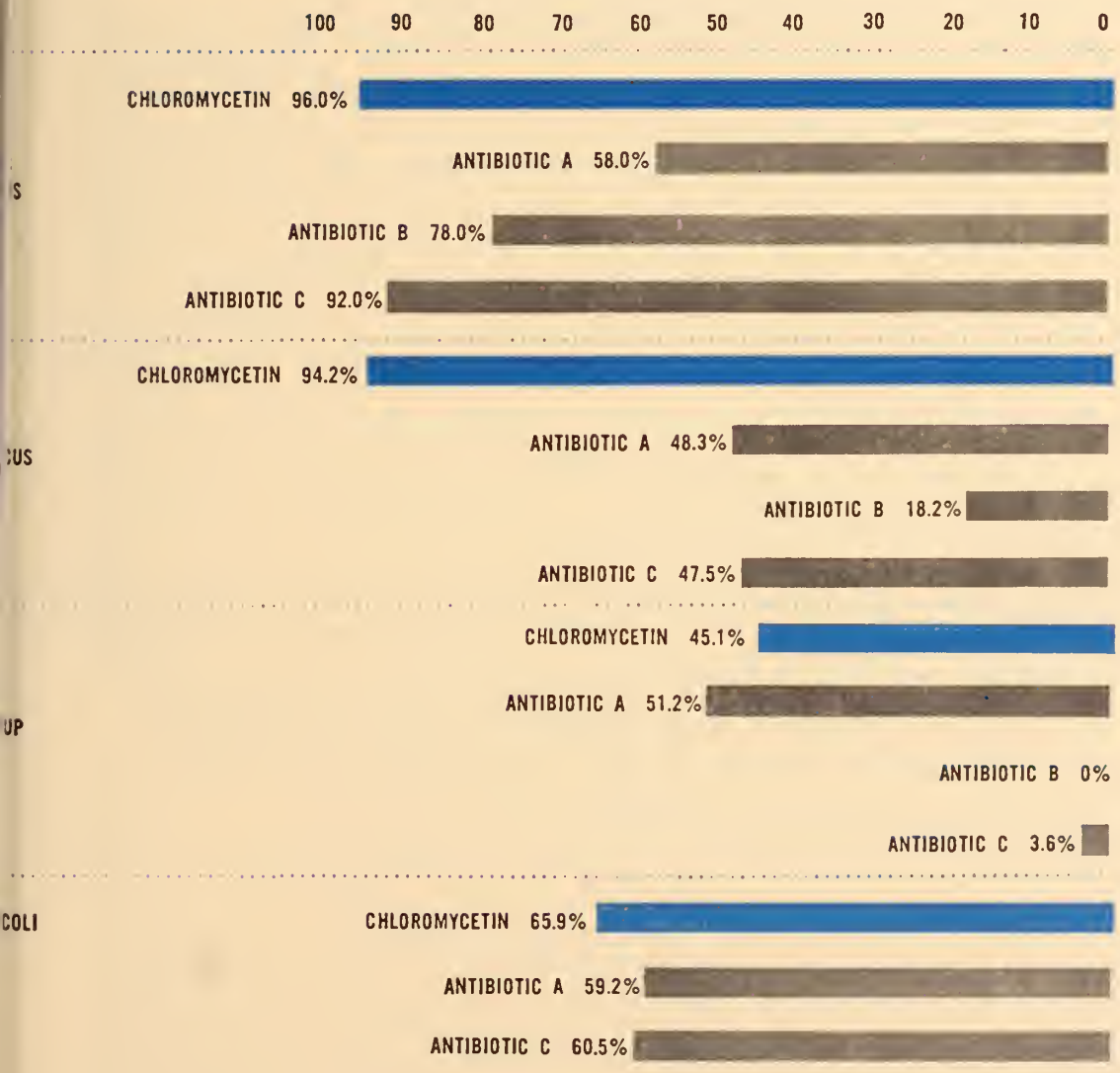
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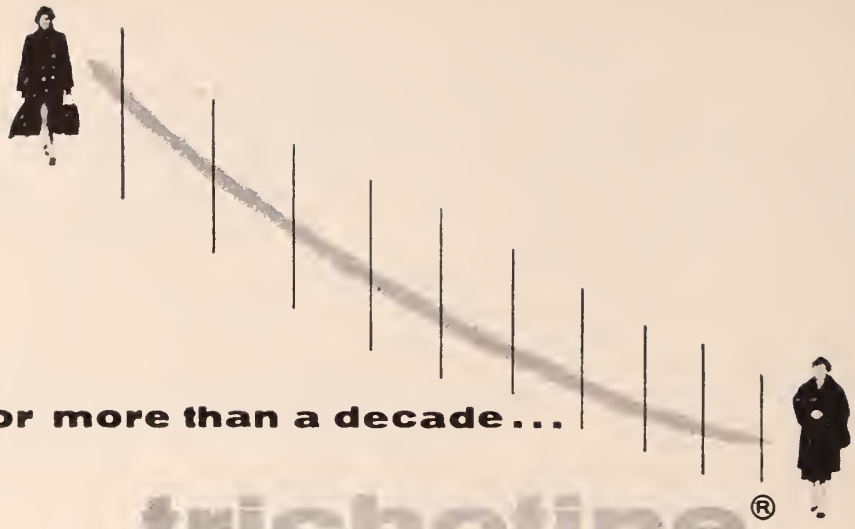
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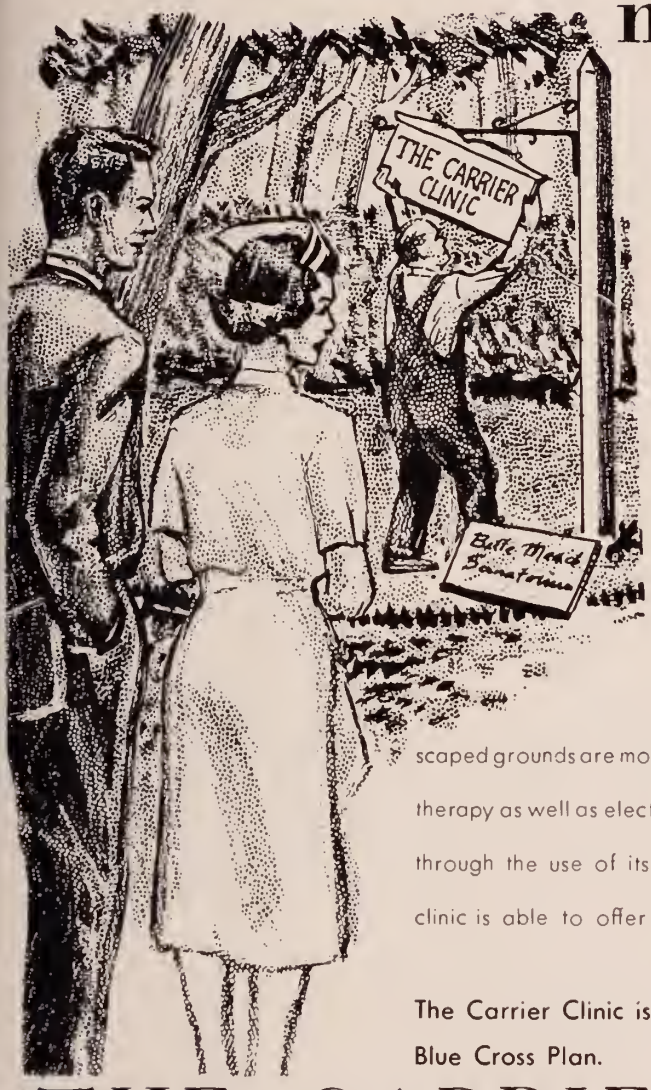
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A new *sign* in the search for mental health



The long-established Belle Mead Sanatorium, located near Princeton, New Jersey, is now called "The Carrier Clinic". The Carrier Clinic will, of course, carry on the traditional purpose of Belle Mead to apply the most advanced psychiatric techniques to the care of the emotionally disturbed. And too, the clinic now has added accommodations for the arteriosclerotic and the senile.

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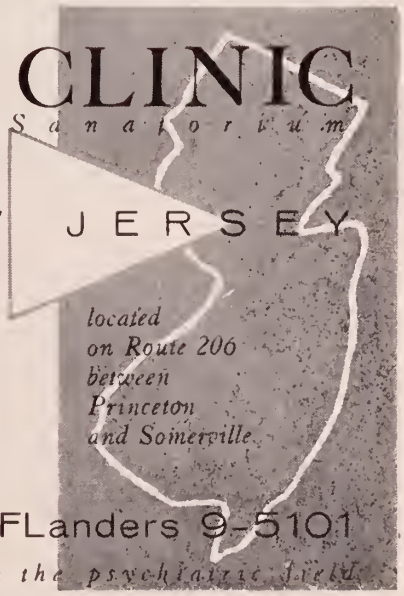
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(1) Halt, J. O. S., Jr.: Dallas Med. J. 42:497, 1956. (2) Gelvin, E. P.; McGavack, T. H., and Kenigsberg, S.: Am. J. Digest. Dis. 1:155, 1956. (3) Natenshan, A. L.: Am. Fract. & Digest Treat. 7:1456, 1956.

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ATARAX produces its calming, peace-of-mind effect without disturbing mental alertness. In the tension/anxiety conditions for which it is intended, you will find ATARAX effective in about 9 of every 10 patients.

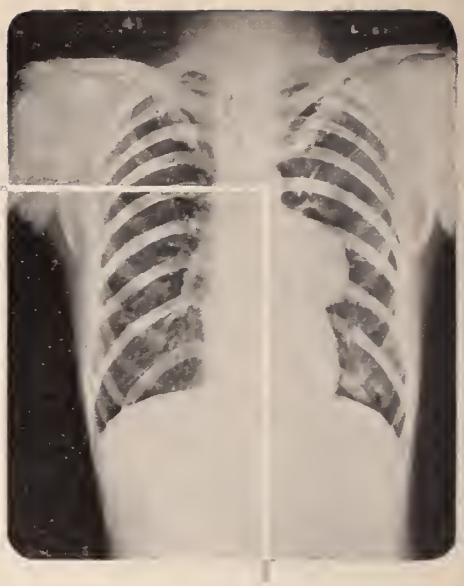
prescribe ATARAX as follows:

Adults: usually one 25 mg. tablet, or two tsp. Syrup, three times daily.
Children: (over 3 years): usually one 10 mg. tablet, or one tsp. Syrup, twice daily.
Supplied: Tablets, tiny 10 mg. (orange) and 25 mg. (green), bottles of 100. Syrup, 10 mg. per tsp., pint bottles.
Since response varies from patient to patient, dosage should be adjusted accordingly. Prescription only.



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Recent Observations

On Self-Regulated Schedules For Infants

Genetically acquired behavioral predispositions enable the normal baby to regulate its feeding intake and periodic hunger sensations, its feeding habits. These physiological regulatory forces may be satisfied by adapting the formula content and feeding period to the individual needs of the infant. It involves a sensible compromise between too rigid a schedule, geared to the clock and too lax a schedule, based on self-demand feedings. Such is the current objective: for either extreme can lead to infant feeding difficulties.

The newborn may become a feeding problem if the prescribed formula is excessive or the feeding schedule rigid. Every time he is awakened abruptly from satisfying slumber to be fed forcefully, the baby gradually loses his enthusiasm for the food and begins to resist the feeding. The young infant may balk at the crude introduction of a new food or feeding procedure without the proper prelude of gradual adaptation of taste, color, consistency and quantity.

The older infant weaned from bottle to cup may reject milk or go on a hunger strike. Devoted to his bottle he resents its sudden deprivation. It takes a certain readiness for weaning to make that change agreeable. Later the infant becomes somewhat independent of his mother and arbitrary with his food. What he enjoyed yesterday, he rejects today. If he distorts the diet for a day and his mother resorts to force, a feeding problem is in the making. Sensible decorum will solve these little difficulties before they become big behavior disturbances in childhood.

The problems of infant feeding are always the same but solutions may differ with each era. The carbohydrate requirement for all infants is as completely fulfilled by KARO® Syrup today as a generation ago. Whatever the type of milk adapted to the individual infant, KARO may be added confidently because it is a balanced mixture of low sugars, easily mixed, well tolerated, palatable, hypoallergenic, resistant to fermentation, easily digestible, readily absorbed, non-laxative. Readily available in all food stores.

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Behind Every Karo Bottle . . . A Generation of World Literature

Announcing a unique new rauwolfia derivative...

First report on one of the most encouraging advances in psychopharmacology since the introduction of rauwolfia: a tranquilizing-antihypertensive agent which combines the potency of the rauwolfias with significantly fewer and milder side effects.

In mid-1955, Abbott Laboratories released for clinical t
new alkaloid of *Rauwolfia canescens*. This new alkaloid,
named Harmonyl, received special attention because o
high potency and low toxicity it exhibited in extensive p
macological testing.

Since that time, Harmonyl has been tried in conditions ra
from mild anxiety to major mental illnesses and in hype
sion. Every characteristic of the drug was studied . . . evalu
. . . compared. And from the reports, one fact stands out

- In more than two years of clinical evaluation, Harmony
exhibited significantly fewer and milder side effects in
parative studies with reserpine. This, while demonstra
effectiveness comparable to the most potent forms of rauwo

- Most significant: Harmonyl causes less mental and phy
depression. *And there are very few reports of the lethargy seen*
many other rauwolfia preparations.

This is not to suggest, of course, that side effects will not o
with Harmonyl—as with any potent therapeutic agent.
the mildness of side effects, in the few instances in which t
have been reported, suggests Harmonyl as a drug of choic
conditions ranging from mild anxiety to major mental ill
and in essential hypertension.

Why fewer and less severe side effects?

Some investigators suggest that the evidence of less paras
pathetic effect with Harmonyl in animals might also be tru
man. In chronic toxicity studies with Harmonyl this was m
fested by less diarrhea, "bloody tears" and ptosis in rats t
was observed with the same dosage of reserpine. Dogs also
hibited milder side effects—in particular, diarrhea. No or
toxicity or hematological change was observed with Harmo
over a wide dosage range.

Harmonyl as a tranquilizer

While Harmonyl's safety is most impressive, clinical investi
tors reported other notable characteristics for this wide-ra

Harmonyl*

(Deserpidine, Abbott)

unquilizer. For instance, following an eight-month study of ronic, hospitalized mental patients, Ferguson[1] reported:

Harmonyl benefited at least 15% more overactive patients an oral reserpine.

Harmonyl was more potent in controlling aggression, quiring only one-half to two-thirds the dosage of reserpine.

A number of patients experiencing side reactions on erpine were completely relieved when changed to Harmonyl.

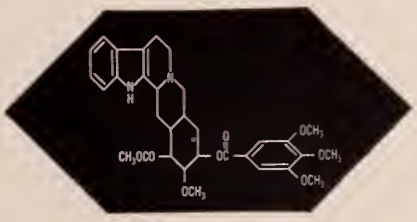
his summary Ferguson concluded: "*The most notable impressions were the absence of side effects and relatively rapid set of action with Harmonyl.*"

armonyl in hypertension

ypertension studies show that the average reduction in blood essure obtained with Harmonyl compares closely to that obined with reserpine. The tranquilizing effect of the two drugs so appeared similar, except that few cases of giddiness, rtigo, sense of detached existence or disturbed sleep were served with patients receiving Harmonyl.

osages In mild anxiety, as little as 0.1 mg. of Harmonyl a y may be effective. In institutionalized psychiatric patients, t less than 2 to 3 mg. a day is likely to be beneficial.

mild essential hypertension, treatment may be started with e 0.25-mg. tablet three or four times a day. After about ten ys (or sooner, depending upon response), dosage may be reced. A maintenance dose of 0.25 mg. daily is often sufficient.



recautions, As with other forms of rauwolfia, Harmonyl ust be used cautiously in peptic ulcer and epilepsy and in tients about to undergo surgery or electroshock treatment. espite infrequent reports involving depression, patients with history of depressive episodes should be watched carefully.

rofessional literature is available upon request.

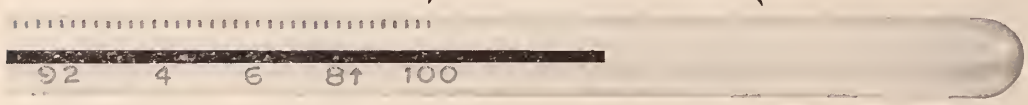
upplied: Harmonyl is supplied in 1-mg., 0.25-mg. and 1-mg. tablets.

Abbott

Reference: 1: Ferguson, J. T.: Comparison of Reserpine and Harmonyl in Psychiatric Patients: A Preliminary Report, Journal Lancet, 76:389, December, 1956.

*Trademar.

can you read this thermometer,



doctor?

Naturally not. Missing calibration makes it worthless.

Equally useless and dangerous is a "quantitative" urine-sugar test that does not quantitate dependably, or omits readings in the critical range.

Enzyme urine-sugar tests are sensitive and specific for glucose—excellent "yes" or "no" tests but undependable for quantitation. King and Hainline,[1] after testing 1,000 urines, found an enzymatic urine-sugar test unable to distinguish in the important range between ½ per cent and 2 per cent or more of urinary glucose. Leonards,[2] in a report on 4,020 tests, revealed that "...in 502 out of 804 tests the wrong interpretation was made." He concluded that enzymatic urine-sugar testing "...as a quantitative procedure is unsatisfactory and can lead to serious error in the interpretation of a patient's clinical condition."[2]

Failure to recognize this limitation of enzyme tests may result in incorrect insulin dosage,[2] and may lead to diabetic complications.

(1) King, J. W., and Hainline, A., Jr.: Commercial Glucose Oxidase Preparations for the Detection of Glucose in Urine, Cleveland Clin. Quart. **23**:212, 1956. (2) Leonards, J. R.: Evaluation of Enzyme Tests for Urinary Glucose, J.A.M.A. **163**:260 (Jan. 26) 1957.

reliable readings throughout the critical range—
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"We prefer to use alseroxylon (Rauwiloid)

since it is less likely to produce excessive fatigue and weakness than does reserpine."[1] Up to 80% of patients with mild labile hypertension and many with more severe forms are controlled with Rauwiloid alone.

1. Moyer, J.H.: J. Louisiana M. Soc. *108*:231 (July) 1956.

A Better Tranquilizer, too

"...relief from anxiety resulted in generally increased intellectual and psychomotor efficiency with a few exceptions."[2] Rauwiloid is outstanding for its *nonsoporific* sedative action in a long list of unrelated diseases not necessarily associated with hypertension but burdened by psychic overlay.

2. Wright, W.T., Jr., et al.: J. Kansas M. Soc. 57:410 (July) 1956.

Dosage: Merely two 2 mg. tablets at bedtime. After full effect one tablet suffices.

Best first step when more potent drugs are needed

Rauwiloid is recognized as basal medication in all grades and types of hypertension. In combination with more potent agents it proves synergistic or potentiating, making smaller dosage effective and freer from side actions.

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In moderate to severe hypertension this single-tablet combination permits long-term therapy with dependably stable response. Each tablet contains 1 mg. Rauwiloid (alseroxylon) and 3 mg. Veriloid (alkavervir). Initial dose, 1 tablet t.i.d., p.c.

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In severe, otherwise intractable hypertension this single-tablet combination provides smoother, less erratic response to hexamethonium. Each tablet contains 1 mg. Rauwiloid and 250 mg. hexamethonium chloride dihydrate. Initial dose, ½ tablet q.i.d.

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The Best Tasting
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with **lower corticoid dosage**

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advantages: (1) greater flexibility of dosage (2) effective tranquilization permits lower corticoid dosage

1. Personal communications

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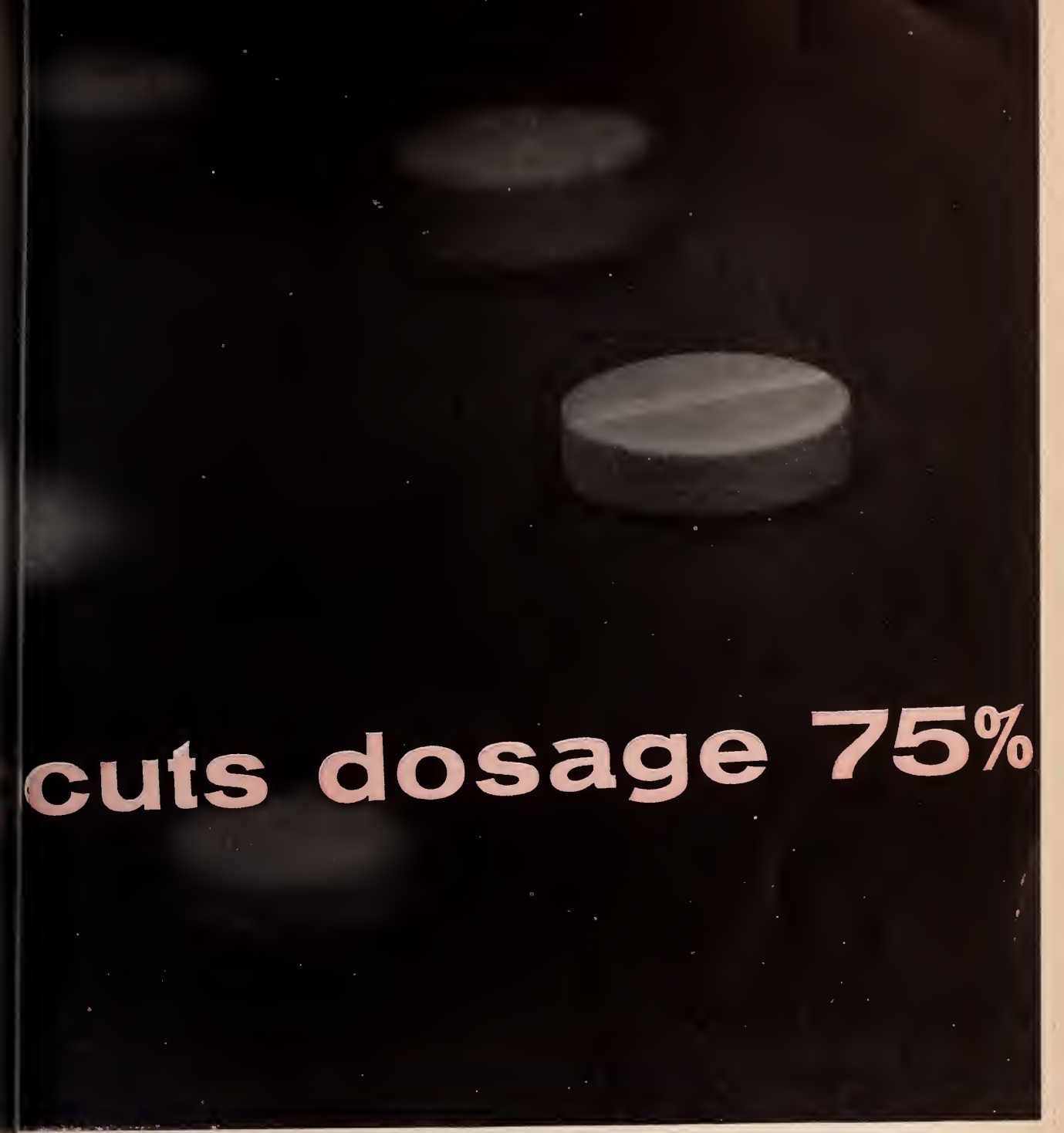
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LOW DOSAGE: a total maintenance dose of only 2 tablets daily.

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SAFETY: KYNEX offers a margin of clinical safety based on low required dosage, solubility, slow excretion rate. Although KYNEX Sulfamethoxypyridazine is a sulfonamide derivative and the usual precautions regarding such drugs should be observed, the low daily dose of 1.0 Gm. is all that is required for therapeutic blood levels. No increase in dosage is recommended.

CONVENIENCE: The low adult dose of 1 Gm. (2 tablets) per day offers optimal convenience and acceptance to patients

TABLETS: Each contains 0.5 Gm. (7½ grains) sulfamethoxypyridazine. Bottles of 24 and 100.

SYRUP: Each teaspoonful (5 cc.) contains 250 mg. sulfamethoxypyridazine. Bottle of 4 fl. oz.

*REG. U. S. PAT. OFF.

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2 BONE CONDUCTION RECEIVERS. Occasionally people with impaired hearing get better results using a bone conduction receiver. This is a special headset for use with the new type amplifier phones and is available with or without a cut-off key.

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Rates similar to that for amplifier phone.

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2. *Meprobamate*—the newest and safest of the muscle-relaxant tranquilizers for profound relaxation of skeletal muscle in spasm.

Tolerance to this combination is good because there is little likelihood of sodium retention, potassium depletion or gastric distress with buffered prednisolone, and meprobamate rarely produces significant side effects in therapeutic dosage.

An additional important therapeutic benefit, often overlooked, stems from the tranquilizing action of meprobamate. This component of MEPROLONE relieves mental tension and anxiety so often manifest in arthritics, making them more amenable to other rehabilitation measures.

INDICATIONS: A wide variety of conditions, in which four symptoms predominate: *a*) inflammation *b*) muscle spasm *c*) anxiety and tension *d*) discomfort and disability; i.e., rheumatoid arthritis, rheumatoid spondylitis (Marie-Strümpell disease), Still's disease, psoriatic arthritis, osteo-

Therapeutic benefits of MEPROLONE compared with traditional a

	relieves pain	suppresses inflam-mation	relaxes muscle	eases anxiety	
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1. Toverud, K. U.; Stearns, G., and Macy, I. G.: Maternal Nutrition and Child Health. An Interpretative Review, Washington, D.C., National Research Council, National Academy of Sciences, Bull. No. 123, 1950, p. 115.
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The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc., and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.



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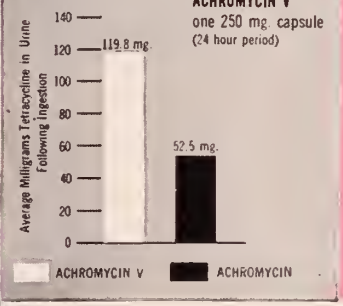
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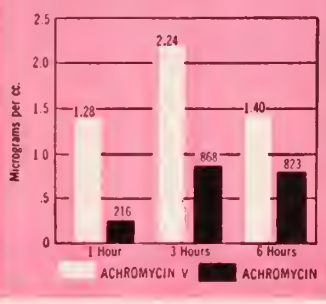
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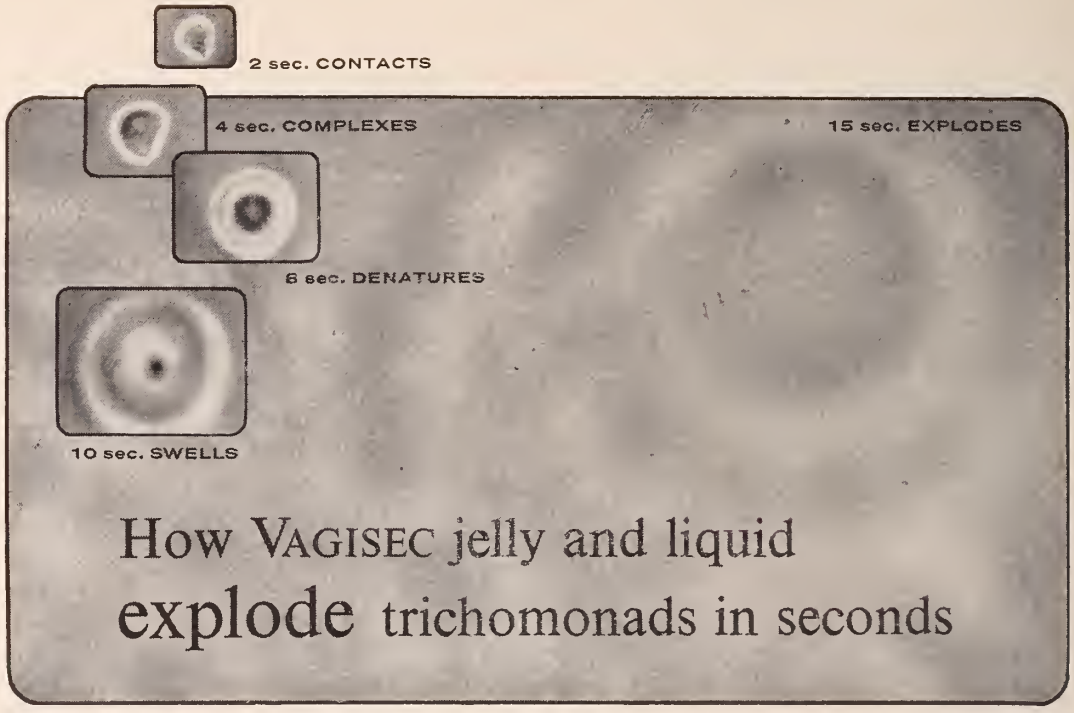
Sodium metaphosphate ..... 380 mg.

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How VAGISEC jelly and liquid explode trichomonads in seconds

VAGINAL trichomoniasis quickly yields to VAGISEC® liquid and jelly.[1-5] These unique trichomonacides *explode* flagellates after 15 seconds' contact. Following a VAGISEC douche, VAGISEC jelly maintains trichomonacidal effectiveness 'round-the-clock. With this new approach, therapy succeeds in more than 90 per cent of cases.[4]

Research proves effectiveness — In hundreds of tests with slide preparations, mixtures of VAGISEC jelly and vigorous cultures of *Trichomonas vaginalis* have been examined under a phase-contrast microscope.[3,6] The trichomonads *explode and disperse within 15 seconds* after contact with jelly — exactly like those in a VAGISEC douche solution.[3-6]

Explosion succeeds — VAGISEC liquid and jelly penetrate rapidly to trichomonads covered by vaginal mucus and cellular debris and *explode* them, avoiding post-treatment flare-ups.[3-5] VAGISEC therapy often rids stubborn clinical cases of "trich" even after other agents fail.

Why parasites explode — A wetting agent, a detergent and a chelating agent, combined in balanced blend in VAGISEC liquid and jelly,[3-5] act to weaken the parasites' cell membranes, remove waxes and lipids, and denature the protein. Then the trichomonads imbibe water, swell and explode into fragments . . . all within 15 seconds.

The Davis technique† — Dr. Carl Henry Davis, co-discoverer of VAGISEC, recommends a combination of office treatments with VAGISEC liquid and 'round-the-clock home therapy with the liquid and jelly.[3] This regimen halts vaginal trichomonal infections and ensures *continuous* control until all trichomonads are gone. For a small percentage of women who have an involvement of cervical, vestibular or urethral glands, other treatment will be required.[1,3-5]

Re-infections can and do occur from the husband[2-5,7,8] — Prescribing RAMSES®, high quality prophylactics, as protection against conjugal contagion ensures husband cooperation. Most of them know and prefer RAMSES — the one with "built-in" sensitivity. RAMSES are superior, transparent rubber prophylactics, naturally smooth, very thin, yet strong. At all pharmacies.

Active ingredients in VAGISEC liquid: Polyoxyethylene nonyl phenol, Sodium ethylene diamine tetra-acetate, Sodium dioctyl sulfosuccinate. In addition, VAGISEC jelly contains Boric acid, Alcohol 5% by weight.

References: 1. Decker, A., and Decker, W. H.: Practical Office Gynecology, Philadelphia, F. A. Davis Company, 1956. **2.** McGoogan, L. S.: J. Michigan M. Soc. *55*:682 (June) 1956. **3.** Davis, C. H. (Ed.): Gynecology and Obstetrics (revision), Hagerstown, W. F. Prior, 1955, vol. 3, chap. 7, pp. 23-33. **4.** Davis, C. H.: West. J. Surg. *63*:53 (Feb.) 1955. **5.** Davis, C. H.: J.A.M.A. *157*:126 (Jan. 8) 1955. **6.** Molomut, N., Port Washington, N. Y.: Personal communication (Jan.) 1957. **7.** Draper, J. W.: Internat. Rec. Med. *168*:563 (Sept). 1955. **8.** Feo, L. G., et al.: J. Urol. *75*:711 (Apr.) 1956.

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*'Seconal Sodium' (Secobarbital Sodium, Lilly)
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THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

The Handy Tradename

Always, some medical pedant is trying to get us to use generic names instead of tradenames. If the surgeon shouts for Adrenalin, he's committing a crime. He should purse up the lips and say "epinephrine." If your chronic alcoholic friend (not mine; mine are abstainers) wants to try a reconditioning drug, you're supposed to advise disulfiram, though no one else will recognize Antabuse under that fancy soubriquet. For epileptics you are urged to advise diphenyl hydantoin, since the heavens will fall if you dare utter Dilantin. Seasick? try meclizine—or dimenhydrinate. Never heard of them? Oh, they are just Bonamine and Dramamine. And so it goes. If the pundits have their way you'll be taking pentobarbital instead of Nembutal and giving your patients meperidine instead of Demerol.

The purists who are trying to squeeze us into this semantic straightjacket are well-intentioned. They don't want us to mention one tradename if there are other equally good brands around. I don't suppose you can say that Equanil is any better than Miltown or *vice versa*, and therefore the generic name, meprobamate would be less embarrassing. So, Achromycin is only one of several good brands of tetracycline, just as Terramycin is but one of many fine brands of oxytetracycline. And the guardians of our language want to avoid the charge of brand favoritism.

It seems to us, however, that all this pedantry is missing the point. The purpose of language is to communicate. If you get up at a medical meeting and tell the doctors that you have been able to put your patients to sleep with parafynol, they'll go looking for some kind of paraffin, though plenty of Dormison is available in the corner drug store. You will have failed to communicate. I doubt if more

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than one doctor in ten will, without looking it up, recognize such generic names as disulfiram, thiopental, hexobarbital or meclizine.

That being so, you have to be awfully stubborn to keep speaking a language your hearers and readers don't understand.

Let's face it. We ask for Coca-Cola, Vaseline, Frigidaires, and other brand-named products because we know that the companies stand behind them. If it weren't for the protection offered by the tradename, many American companies would not continue to produce. Why should a drug manufacturer sink millions in research and promotion, if some less solid manufacturer can cut corners, make a second-rate imitation, use the same name, and reap the rewards of the first company's labors? If you have ever used the shoddy products put out in some foreign countries, you'd be grateful for brand-named items.

When I say Adrenalin, Benzedrine or Combiotic, that what I mean—and not some pedant's "pharmaceutic equivalent."

And if my patient goes into heart failure, I'll shout for a brand name product like Cedilanid. He'd be dead by the time I could say "desacetyl lanatoside D."

Blue Shield is Different

"Isn't Blue Shield just 'another insurance company'?" This question usually comes from a member of the generation of new doctors who have come into practice in recent years, and who are not fully aware of the desperate challenge that gave rise to the Blue Shield idea and the hard work with which its accoucheurs gave it birth.

Blue Shield is a vast and triumphant effort on the part of American medicine to demonstrate that doctors *can* solve urgent problems of medical economics without government interference. Blue Shield was created at a time when insurance experts questioned the actuarial feasibility of large-scale voluntary medical care insurance. At that time, many doctors feared that a voluntary program would lead to a compulsory government health insurance system.

Blue Shield is different from commercial accident and health insurance. The insurance company underwrites selected groups to produce a profit. Blue Shield (reflecting the service ideals of our profession) makes its services available to the entire community, at rates based on the needs and experiences of the community. This particularly includes low income groups who most need medical prepayment protection.

Commercial insurance companies offer cash allowances which may or may not have any relation to the doctor's normal charge for his services. Blue Shield's schedules of payment are approved by the local medical profession. Blue Shield benefits may take the form of fully paid professional services, through the cooperation of the "participating physicians." Even where "service benefits" are not provided by formal agreement of the doctors, Plan schedules conscientiously try to approximate the normal charges of the local physicians for services rendered to patients in lower income brackets. Local physicians frequently accept these fees as full payment.

Blue Shield Plans are distinguished by nonprofit operation. Thus, all the funds contributed by the subscribers are available for payment of benefits, with a minimum retained for actual operating costs and reserves for future claims.

Over and above all requirements of state law, Blue Shield Plans are required to maintain strict "membership standards." These standards provide that the Plan must have the continuous approval of the local medical society; must render an annual report to the society; and must secure the formal participation of at least 51 per cent of the licensed physicians in the Plan area.

To be sure, Blue Shield utilizes insurance principles. But, because of the participation of the great majority of American physicians, it is able to transcend the limits of insurance—to become a true community service on behalf of the public and the profession.

Bachelors Die Earlier

Whether a bachelor's life is a merry one is a matter of opinion. That it is a shorter one is a matter of statistics. Only their psychiatrists can tell us whether the bachelor's freedom produces enough merriment to neutralize the loneliness of solitary nights at the television set, a deserted old age, or the awful sense of rejection that occurs to a non-family man when he is sick in bed at home. But every time the statisticians take another reading they come up with the same result. Current figures for the age 60 to 69 decade show a male death rate (per thousand in the group) of 48 for single men, 40 for widowers, 56 for divorcés, but only 31 for married men! Among women the differences were less marked, except that divorcees had a consistently higher death rate than spinsters, matrons or widows.

Why should married men live longer? The factor of physical selectivity before marriage cannot play much of a role, since the differential in favor of married men is true at every age. It may be that wives keep their husbands healthier by insistence on the spouse's wearing mufflers, hats, overcoats and rubber overshoes in the rain. Perhaps the married man watches himself more carefully because he has so many mouths to feed. Maybe marriage means more regular hours, better (home cooked) food and less dissipation. Or maybe marriage was made for man and man was made for marriage. Anybody got any better explanation?

Read Well Before Signing

We doctors are always getting cards from drug manufacturers and other benefactors offering free samples if we will but check on the return card. Or, by initialing on the self-addressed, prepaid postcard we can get a beautiful two-toned wall chart showing the differential diagnosis between Rocky Mountain Spotted Fever and bubonic plague. So, sometimes we get a little careless and initial anything that comes our way. This has become an automatic reaction, leading to a collection of calendars, memo pads, ball pens, hypodermic kits, and blotters, all gratis. In some offices, the secretary has been given a general order: relay all postcards suitably checked and initialed.

As a result of this reflex action, a number of New Jersey physicians now find their faces a bit red. It seems that the Euthanasia Society circularized doctors asking support for a petition presented to the Legislature earlier this year. The instruction was to *print* your *name* (M.D.'s signatures being notoriously illegible) and check a box which authorized use of your name as a signer of the petition. Now, it appears, that many of the signatories said that they never supported euthanasia and that it is all a mistake. In some cases, the nurse or secretary rubber stamped the name apparently while in a somnambulistic state. Some said they inadvertently checked the "yes" box when they meant "no." A few physicians keep a stock of miniature stickers with name and address, and these were pasted on to the card by sample-happy or souvenir-collecting office personnel.

Your name is more precious than your bank-account, and it ought to be more jealously guarded. A rubber-stamp or a printed sticker carrying your name and address can be misused by careless people in your office. Such personal identifications should be controlled with something more than "routine" care. If a doctor is too busy to see what use is being made of his name, he will some day find himself on the wrong side of the fence. His invitation to oblivion will have been signed by himself.

Hilton S. Read, M.D.

Ventnor

"What the Physician Thinks of the M.D."*

The doctor is a many sided man. Dr. Read here reports on a poll of an age-specific sample of physicians who tell what they think of each of the six facets that make up the complete physician.

When the invitation to participate in this conference was received, the inherent booby trap of using it as a rostrum to ventilate personal bias was recognized. To minimize that possibility 200 physicians, 50 in each decade aged 25 to 65 years, have been polled.

Included were bag-toting, door-bell-pushing doctors in an overgrown fishing village; super specialists of the Ivory Towered Medical Meccas; interns in community hospitals; residents of university hospitals; medical directors of large industries and of insurance companies, diplomates in Average Town, U.S.A., AMA Statesmen and county society "ward heelers." No pun intended.

This morning's presentation reflects their audit of the balance sheets—the credits and the debits: "What The Physician Thinks of the M.D."

Your speaker is only a poor facsimile of Univac—wired for sound to transmit the results. In the interest of staying within the allotted time the credits (of which we are all justly proud and sometimes immodestly articulate) will not be recounted, so that I am the courier of the debit-side-of-the-ledger, only.

No effort has been made to load the results, water down the indictments, editorialize or rationalize. The time limit necessitates a blunt monosyllabic delivery of statements that perhaps deserve softer words and some qualifying discussion.

This inventory concerns itself with six elements that among others make up the complete physician. (1) As a scientist, (2) as a humanist, (3) as a citizen, (4) as a colleague, (5) as a parent and (6) as a philosopher.

SCIENTIST

There is almost universal enthusiasm among doctors over the scientific qualifications of other doctors. There is an occasional reservation that we are becoming victims of the automation age; that we expect roentgenograms in the pushbutton age to come out of the developing tank with the diagnosis embossed on the liver shadow; that we are being seduced by gadgets and tests so that we forget that "common things are common;" that we sometimes neglect our special senses and are loath to look, listen, feel, smell, and even taste; that we have forgotten David Riesman's admonition that "he would forgive me for not knowing, but he would never forgive me for not looking."

Some support for this charge can be found in the disinclination of professor and intern

*Read at the Public Relations Conference of the Medical Society of Pennsylvania on October 22, 1956. Dr. Read is Director, The Ventnor Diagnostic Center.

alike to face up to the ultimate fact that diagnoses have to be finalized and their use of the whimsical crooking of the neck and furrowing of the brow, while they come up with the delaying suggestion of another rare and unproved test on the morrow.

HUMANIST

A VERY dear friend of mine, the wife of one of your distinguished surgeons, scolded me recently about my repetitious references to the art of medicine. Use of the term "humanist" is a device to evade her wrath.

Thirty years ago my widowed schoolteacher-mother, floated around our home town medical community months with a multiplicity of complaints because some doctors were mind readers. She never got to finish a sentence before she was told "Yeah, I know, I know." The hospital administrator, seeing her pass one day, insisted upon her coming in for a blood count. She had been walking around with 5 Grams of hemoglobin. It was then that she insisted that I continue my medical training through a residency, rather than quitting after my internship. In repayment she extracted a pledge from me to "Let the patient talk himself out and to strip and examine him." She must have required a slightly larger halo last week as she overheard an 85-year old man say to me as I percussed his chest, "Doctor, you are kinda old fashioned, aren't you? I haven't been to a beatin' doctor in a long time."

It is as a humanist that we can make our greatest contribution to the welfare of our patients, despite the fact that some people may be irked by the emphasis in this atomic age on "the art of medicine." The greatest dividends in improved public relations may come through the minutia of trivia that we consider under this catch-all heading of "humanist."

Five minutes of chit-chat by the surgeon at the pre-operative bedside of a patient may contribute incalculable acceleration to the recovery of that patient. Some years ago I sent an octogenarian patient to a distant medical center for the repair of a large hiatal hernia. The surgeon spent 5 minutes with the patient the day before he operated, explaining among other things that when she "came to" the next day she would have a tube coming out each nostril. It would not be that she had done badly or that she was seriously ill. It was just his routine. Later, the patient told me it was the greatest satisfaction in the world to "wake up," feel for the two tubes and find them both in place! She knew she was shooting par!

We should be careful in explaining instructions to our patients. They should be written. Mother and daughter can come in the office and you can say to the mother, "You are to drink 8 glasses of water a day," but when they return to their car — unless the instructions are written — the argument begins as to whether it was 8 glasses a day or 1 glass in 8 days.

IT WOULD be a good thing if we doctors could stand aside and look at ourselves once in a while. We might be surprised to find that more consumers choose medical care on the basis of affability and availability rather than ability. Prestige of Phi Beta Kappa and A.O.A. keys on the watch chain may have no effect on the patient if their owner has dandruff on his shoulders or dirt under his fingernails.

We need to inquire into our bedside manners. We need to inquire into our manners!

It wouldn't hurt medical schools to include a course in merchandising as the cult schools do. It wouldn't hurt a few of us to take a Dale Carnegie course or go to the equivalent of an Elizabeth Arden Charm School. Some medical schools realize this and are apprenticing third year students for 6 weeks to preceptors practicing in communities distant from medical centers.

Some industries call in specialists from the outside to analyze the effectiveness of their technics. We ought to do the same thing. We could accomplish it by allowing long-time patients, trusted colleagues or our families to run a critique on us each birthday. Our wives can be of great assistance in helping us analyze ourselves. The protoplasm of many of us is too jelled to "take it," but we and the

consumers would be better off if we could. We might learn many simple little things that irk the patient, impede his recovery and dilute our usefulness, such as the corny joke, old magazines in the office, dust in the corners, unclean towels on the examining table, failure to wash our hands in front of each patient, cold treatment rooms, and dull needles.

We ought to get rid of cranky personnel in our office. The first telephone call to your office by a patient for an appointment and the way it is handled may be more important in the chain reaction toward health than a load of Miltown®, shock therapy, or a cholecystectomy. Repaint your office, change the draperies often, alternate the pictures and the decorative nicknacks monthly, keep a flowering plant and a business form receipt machine on your secretary's desk, place the AMA sign inviting discussion of fees in view on the wall, the House and Garden loose-leaf *Do-It-Yourself* book, and the Bible on your waiting room table. Then see how much easier your patients are to get along with when you are running behind schedule and how much your cash receipts step up. Set up your sound proof consultation room like the living room of your home. Throw out your plate glass covered orthodox desk which makes opponents of patient and doctor as they glare across it at each other. Use a round table under which both you and your patient can stretch your legs. Keep a fire going in the fireplace if you have one and see how much better the patients ventilate when giving histories. Take time to explain in words of one syllable what you want the patient to know.

Blood counts, urinalyses, x-ray reports, and so forth, are commodities. The patient has the same right to these reports that he has to a pound of sugar or an overcoat when he pays for them at his favorite store.* This saves costly repetitious testing and may be of inestimable future value to the patient and doctor alike. Many of us have had the disturbing experience of asking a patient when he had a blood count or urinalysis and have him say he had one 6 or 12 months ago, but he didn't know what it showed. "It must have been all right because I never heard from the doctor."

Arrange adequate coverage by a qualified colleague when you are going to be out of touch with your office, at the theater, on a football weekend or on vacation. The worst possible public relations existed in a town where all the doctors took Thursday off. Agreement by half the doctors to take Wednesday and half to take Thursday produced a bull market in local public relations. Orient your patient on how to change doctors when he moves or becomes dissatisfied with you. Offer to make his records available to any physician whom he suggests. Explain to him that this relieves you of worrying about his condition when you are no longer responsible for him. Often when they know how to change, they don't want to change. Volunteering data to the new medical adviser of your former patient may be regarded with a discouragingly curt "I'm not going around stealing your patients." You must occasionally endure this ungracious penalty in the interest of the welfare of the patient and the profession.

Try to take time to orient your patients on their care while in the hospital, explaining among other things, hospital and medical charges. The AMA Brochure *To All My Patients* is a valuable aid.

CITIZEN

Take off the austere white gown and put on the blue denim overalls of Mr. Average Citizen more frequently. We ought to grab a spade and work in the vineyards of human relationships oftener. We need to be willing to accept committee memberships in organizations like the Boy Scouts, Chamber of Commerce, the Little League, YMCA, Catholic Youth Organizations, and so on. We ought to join our ward political club or else "shut up" about the quality of candidates offered us. We ought to belong to church and attend regularly; or else quit griping about the teen-age

*Many practitioners and some courts say "no." The roentgenologist is not "selling" celluloid. The cardiac patient is "buying" professional time and a professional opinion and not a paper tracing—Editor.

problem. We ought to be moderate in our smoking and drinking or else be prepared for our children (and our patients) to mimic us. In other words, we ought to be putting a little more leg service in the activities that we so glibly support with lip and check service. And speaking of check service we have nothing to be too proud of in our organized giving, despite the fact that we hold a favorable position when compared with other professions. The United Fund and Council of America reported that only two-thirds of all doctors contributed to its member organizations in 1954. Those contributions averaged $48 annually per doctor. All too numerous are the $10 contributions to the Community Chest by doctors who trade their Cadillacs in yearly.

COLLEAGUE

Some doctors reported they are irked by papers that inferentially or openly accuse the general practitioner of delays in diagnosis and therapy. They would like some surveys directed at the specialist, *his* delays, *his* repetition of blood counts, electrocardiograms cholecystograms, and chest x-rays because "he wants to arrive at his own unbiased opinion." It is hard to estimate the psychogenic trauma done by the lifted eyebrow of the consultant or the tactless sniff of a specialist when he looks at a film the patient has lugged along from his local medical doctor and then without a word of explanation requests a repeat x-ray. Some professors apparently think that x-rays taken in a town of under 100,000 are worthless. Sometimes one medical center doesn't trust the films of another only a few blocks away and repeats the examination even with a perfectly acceptable diagnostic film done three days prior. This infuriates the patient and indicts the whole profession in his mind; adds a super charge of anxiety and contributes to many iatrogenic diseases. These thoughtless actions also add converts to the cause of tax supported medicine.

Too often no effort is made to research into the past history of patients. A phone call or a short note might produce a reservoir of information that would sharpen the diagnosis quickly and shorten the hospitalization. Too often on hospital records we see a note "History Unavailable." Five minutes of the intern's or resident's time invested in a phone call might develop the helpful fact that the patient has been on insulin for 2 years and abandoned it or had taken digitalis for a year and a half without any opportunity of followup for the family physician. More often than not these calls are not made and this research is not done because the present medical adviser is embarrassed about calling the previous one. Society is paying too high a debt for this embarrassment. Medical center clinics to which patients are referred by family doctors sometimes inadvertently underrate the referring doctor and overrate their own capabilities; or they mislay the name of the referring physician so that the patient never gets back to the original source. Follow-up reports from such centers are discouragingly minimal. Too often there is a long lapse between the discharge of the psychiatric and surgical patients, especially, and the receipt by the family doctor of the reports so that there is a serious hiatus in treatment—and the patient's family wonders why. Fifteen minutes after patients are scheduled to be on the operating table in a city 60 miles away, the family doctor will be called by the family at home inquiring "What was found?" A telephone call from the surgeon or his resident at the conclusion of the operation would do a great deal to improve public relations by allaying anxiety on the part of family and referring doctor alike.

Overemphasis of the trivia may inflate the ego of the consultant before he removes a ureteral calculus when he asks "Didn't your doctor tell you you had a murmur?" The family doctor may have known it for 30 years and had been doing a good job of avoiding iatrogenic disease; but because the professor has figuratively lifted his eyebrow the home town doctor becomes a jerk. While testifying as an expert in a rural county seat, a top flight neurologist caused serious disruption in a local doctor-patient relationship. He glibly prescribed Equanil® ("the never fail drug") for the trial lawyer who had asked some curb-stone

advice for his headaches, not realizing the local doctor had been skillfully managing his renal insufficiency problem for 18 months.

PARENT

THE unanimity of our pollster's opinion on doctors as parents was discouragingly convincing. There was agreement that doctors are good fathers but that the great majority are poor parents. They leave the raising of their family to their wives. Quick with their check books they are slow on diaper changing.

PHILOSOPHER

AND as the old minister said — finally — but not immediately—we consider the doctor as a philosopher. Grousing at cocktail parties, in the scrub room of the operating suite or in the hospital elevators (where patients' families and friends have flapping ears) may be dignified by some as philosophizing; but in general it is an unproductive and sometimes dangerous waste of energy. What is really important is not to be a back-bench mumbler but to stand up and be counted in county medical society meetings and in staff sessions, or we deserve what we get! We have to inform our delegates to the State Society and the AMA how we feel about the abuses of Blue Shield, Blue Cross, accreditation, the Council on Medical Education and Hospitals and the emotional blackmailing by some medical school deans which frightens their seniors away from internships in community hospitals.

Only twenty years ago a motion to inquire into the desirability of pre-payment medical plans was defeated in the House of Delegates of the AMA 162 to 4. Olin West, then general manager and secretary said that every pre-payment plan was fraught with danger. We must support our philosophy by our vote — and yours is important.

Creeping socialism encouraged by tax supported medicine or inaladministered Blue Shield and Blue Cross is equally devastating. We deserve the obvious penalties if we support the philosophy of gallantry and senility and year after year vote to continue the same tired brains on the same Boards of Overseers. All of us know that the cost of bed and board, and a host of other services in the hospital are being tacked on to the bill that the entire economy has to pay because we haven't modernized our technics for distributing diagnostic services about which we boast so much. A sizeable proportion of our profession is blinded by the immediate expediency of self and has a blurred concept of long range welfare of the profession and the consumers of medical care, whose interests are mutual and complementary.

THE COMMUNITY HOSPITAL

ACCREDITATION insists upon a routine blood count. A well qualified doctor does a blood count on the patient with a possible appendicitis in the middle of the night. The surgeon is called and agrees on the need for an operation. But on admission within the hour the blood count has to be repeated. An extra charge has to be made against the patient or Blue Cross. The debasing feature of it is that the blood count may and often is done by a neophyte technician, but the hospital will not or cannot accept the blood count done at the patient's home and submitted over the signature of a certified internist. Thus an M.D. is low-rated compared to a technician.

Support can be produced for the philosophy that a rotating internship in a good community hospital has more to offer a graduate than does one in a University hospital where he is squeezed between the student clerk, and the first year resident. Getting him off the academic teat for a year into a community hospital where he can "do-it-himself" and can see how 95 per cent of the medical care of this country is distributed and then having him return to the university for his residency may be a valuable contribution to the future of medical care. The trouble is that the Medical Centers where 5 per cent of the medical care

of this country is done produce 95 per cent of the published papers and exercise 95 per cent of the influence on the Councils. When the Council on Medical Education and Hospitals was loaded with deans years ago, a resolution was introduced into the House of Delegates of AMA requiring that one member had to be a man not on the faculty of a medical school and not a member of the staff of any hospital connected with a medical school. It was defeated in the Reference Committee when the Editor of the *Journal*, the President of the American Medical Association, the speaker of the House of Delegates, two distinguished and influential members of the Pennsylvania delegation, and the radiologist of the Mayo Clinic appeared and spoke against it. But on the floor of the House of Delegates there were sufficient aroused votes to override the Reference Committee and to make it a part of the By-Laws of the American Medical Association.

A Pennsylvanian, now a member of the senior class of a Philadelphia medical school would like to return to his home town hospital (an excellent one, by the way) for his rotating internship which is the accepted prelude to future practice and staff appointment there. He contemplates a residency in surgery at a university hospital. A professor has all but convinced him that he is blighting his career to return to the home town hospital for internship. The same professors and deans who make it so tough for the community hospitals to secure house officers need not be surprised at the reluctance of the community hospital staff to contribute to the Alumni giving fund.

The community hospital is threatened with having approval withdrawn if it doesn't cooperate with the National Intern Matching Program. But operating within that framework in 1954, a community hospital matched with an intern who failed to report on the appointed day. Ninety days' correspondence between the hospital and Matching Program, Inc. followed until the matter was finalized by the following letter dated Sept. 30, from the managing director of the Matching Program. I quote:

> We have never received an answer to our letter of July 30 to Dr. Blank, who was matched to your hospital in the last matching program. In cases of this sort where there is refusal to go through with the results of the matching agreement, on the part of one party, it is customary to request a statement from each party. Copies of the complete file are prepared and submitted to the Board of Directors for their action. After their approval the file is forwarded to the Biographical Records Section of the American Medical Association—there to be made part of the permanent record.

The Medical Center brass until they started to hurt for interns and residents had little or no interest in the problem of the foreign graduate except to rush into print with sweeping indictments about their "mediocracy." Now they propose to counteract our State Department good will program abroad by setting up a super examining bureau that indicts the foreign graduate's diploma and license as second class. It is planned to make it obligatory for all hospitals to secure their foreign interns through this bureau. If the community hospital doesn't get short changed on this deal a new era in medical bureaucracy will be dawning. The following is from an official communication from the American Hospital Association dated September 25, 1956 and signed by an M.D.

> "An important point to remember is that once the program goes into effect the American Hospital Association is going to withdraw, withhold or deny listing to hospitals which appoint graduates of foreign medical schools who have not successfully passed the screening examination of the evaluation service. Further, the Council on Medical Education and Hospitals of the American Medical Association will deny, withhold or withdraw approval for internships to hospitals appointing the unsuccessful examinee. We feel that these will be very powerful deterrents to the appointment in the hospitals of the unqualified medical graduates. The short range effect of this program I suppose will be to reduce the number of foreign medical graduates rendering patient care in the hospitals in the United States. But this will be a very desirable consequence if the services rendered by some portion of the foreign medical graduate is inadequate under the existing system."

One of the most challenging citizenship responsibilities we doctors have is the training of succeeding medical generations. Three words that we ought to delete from our discussion are "In my day." We must assume a

very definite and personal interest in the social, professional, scientific, cultural, physical and spiritual welfare of our house officers. We must take them into our homes and let them see how we live and what our philosophy of life is. Enjoying Hi-Fi music together is as important as holding retractors together — or more so. A few hours spent in his chief's private office and living room or hobby shop during a rotating internship may be a more valuable experience for an intern.

These random items, just a sampling from the debit sheet conclude "What the Physician Thinks of the M.D." Once again permission is asked to remind you that I was your servant in this research, your reading clerk of this audit, and only your animated Univac wired for sound.

5407 Atlantic Avenue

New Jersey Society of Internal Medicine Organized

The New Jersey chapter of the American Society of Internal Medicine met on February 3 in the Medical Society Building in Trenton. More than seventy specialists in internal medicine came together to organize the New Jersey Chapter.

Dr. Sherwood Vine of Trenton presided as temporary chairman. He was subsequently elected as the first president of the organization. Elected to serve with Dr. Vine are Dr. Frederick Hnat of Elizabeth, vice-president and Dr. Howard E. Topley of Trenton, secretary-treasurer. The following committees were appointed by Dr. Vine:

Executive Committee: Dr. Louis F. Albright, Dr. Edward C. Klein, Jr., Dr. Hilton S. Read, Dr. Herman H. Tillis, and Dr. Peter J. Warter.

Insurance Committee: Dr. Andrew J. Klein, Dr. Albert Abraham, Dr. Louis F. Albright, Dr. Jerome G. Kaufman, and Dr. James F. Gleason, Atlantic City.

Credentials Committee: Dr. Harold K. Eynon, Dr. Thomas J. White, Dr. Edward C. Klein, Jr., and Dr. Nathan Swern.

Constitution Committee: Dr. John Winslow, Dr. F. Clyde Bowers, and Dr. Joseph W. Gardam.

Public Relations Committee: Dr. Horace M. Shaffer, Dr. William P. McCarthy, and Dr. George A. Hess.

Medicare Committee: Dr. Harry A. Kaplan and Dr. John A. Kinczel.

Finance Committee: Dr. J. F. Pessel.

Liaison officer to State Society: Dr. Peter J. Warter.

The Society will hold its next meeting on Sunday, March 31, at the Medical Society building in Trenton.

Memorandum on Maternal Mortality

This twenty-three year old primigravida had a normal prenatal course up until the thirty-fifth week with a blood pressure of 120/70. At this time her blood pressure was found to be 135/90 and the urinalysis was reported as two plus albuminuria. The patient was permitted to return home.

Five days later, she had a convulsion at home. She was rushed to the hospital. Her condition grew steadily worse and twelve hours after admission she expired.

Autopsy findings were: (1) Cerebral hemorrhage; (2) Necrosis of the liver, and (3) Necrosis of the kidney. Diagnosis was death from eclampsia.

Comment: Albuminuria in the pregnant patient must always be considered a sign of danger. In addition, this patient had a concomitant elevation of blood pressure. Had she been admitted to the hospital on the day the albuminuria was detected and proper treatment started, it is possible that her life could have been saved.

Prepared by the Special Committee on Maternal and Infant Welfare.
John D. Preece, M.D., Chairman.

William Levison, M.D.

Newark

Manifestations of Latent Diabetes During Pregnancy*

Sometimes a pregnancy unmasks a latent diabetes. Each condition complicates the other. The death rate among fetuses and newborns seems to be unnecessarily high in these cases. Dr. Levison here compactly reviews a common but little discussed medical problem.

Pregnancy is known to aggravate diabetes mellitus. Some even believe that pregnancy may *cause* diabetes. More likely, pregnancy helps manifest an otherwise latent diabetic state. Six cases are presented here which (a) show that it is often possible to recognize the prediabetic state during pregnancy; and (b) reflect some of the problems of management.

CASE ONE

A 23-year old woman was admitted to the Newark Beth Israel Hospital in the eighth month of her first pregnancy with sore throat, fever, malaise and a painful left shoulder. During her visits to the prenatal clinic, glycosuria was noted on two occasions during the fifth and sixth months of pregnancy. A fasting blood sugar, obtained during the fifth month, was 100 milligrams per cent. There was no history suggestive of pre-existing diabetes and no known family history of diabetes.

On admission, she was toxic. Temperature was 102, pulse 156, respiration 36 per minute. Blood pressure was 108/68. The pharynx and tonsillar areas were markedly inflamed. The left shoulder joint was tender and motion was limited. The uterus was the size of an eight month gestation. There was profuse, thick yellow vaginal discharge. Labia was tender and indurated.

She was drowsy most of the time and had a hectic temperature for 72 hours. Within 12 hours after admission the fetal heart sounds were no longer heard and the fetus was presumed dead. Nose, throat, vaginal and blood cultures all showed staphylococcus aureus. Fasting blood sugar the day after admission was 320 milligrams per cent.

Following treatment with penicillin and Terramycin®, the patient's temperature became normal. On the fourth day, medical methods of inducing labor were tried without success. At this time, the patient was noted to have hyperglycemia of 700 milligrams per cent. There was minimal or no glycosuria or acetonuria despite adequate urinary output. On the fourth day a Vorhees bag induction was attempted. The vaginal mucosa was friable and bled considerably. Abscess pockets in the vaginal wall were seen. For the twelve hours immediately following the insertion of the bag, only 100 cubic centimeters of urine were collected. The patient did not appear clinically to be in shock. For twelve hours preceding the bagging, urine output had been 1160 cubic centimeters. The oliguric urine was clear, yellow, with a specific gravity of 1010. It contained no sugar or acetone although the fasting blood sugar was 602 milligrams per cent.

During the succeeding twelve hours, urinary output increased to above 400 cubic centimeters, with two to three plus sugar. Labor was finally initiated and at the end of the fifth hospital day a stillbirth was delivered. With the passage of the baby through the birth canal, considerable damage was done to the friable abscess-ridden perineum. In the succeeding 24 hours, the urinary output was greater than 3 liters and for four days thereafter ranged from 3,000 to 5,000 cubic centimeters a day. Glycosuria was intermittent and, therefore, small amounts of insulin were given, never exceeding 35 units during 24 hours. During the following week the fasting blood sugar fell progres-

*From the Diabetes Clinic of the Newark (N.J.) Beth Israel Hospital.

sively toward normal and glycosuria disappeared in spite of persistence of focal abscesses which had to be incised.

In the fourth hospital week the glucose tolerance curve after ingestion of 100 Grams of glucose was normal. Fishberg concentration test showed the urine specific gravity not higher than 1010. A moderate hypochromic anemia was observed. She was discharged without insulin on the 32nd day after admission. The perineal wound was not healed. Three weeks later, in the outpatient department, blood sugar was 88 milligrams per cent.

A year later, a second pregnancy was terminated in another hospital. The baby died four hours postpartum. The patient said that no sugar was found during her second pregnancy. A year and a half later, we saw her in our Diabetes Clinic. She was in her sixth month of pregnancy and had gained 75 pounds since her last pregnancy. She reported excessive intake of sodas, cake, and ice cream. Polydipsia, urinary frequency and nocturia were marked. Fasting blood sugar was 254. Two weeks later, in spite of immediate dietary regime and insulin, she entered the hospital in diabetic acidosis. More than 300 units of insulin were needed to stabilize her diabetes. She was kept in the hospital for the remainder of her pregnancy (50 days) requiring up to 70 units of NPH insulin daily. A cesarean section was done at 33 weeks and a normal baby delivered weighing six pounds three ounces. Following delivery the insulin requirement dropped sharply and the patient left the hospital a month later, taking 40 units of NPH insulin.

During the next ten months she visited the Diabetes Clinic only twice. She had no glycosuria. She discontinued her insulin five months after discharge from the hospital.

Nine months later, she visited the clinic again, six months pregnant, with one week's history of diabetic symptoms. The blood sugar was 258. She was put on an 1800 calorie diet and 36 units of NPH insulin. She was subsequently hospitalized for one week because of glycosuria and acetonuria and discharged on 45 units of NPH insulin.

One week antepartum the fasting blood sugar was 205. A ten pound seven ounce baby was delivered by cesarean section in the 36th week of gestation and the tubes were ligated.

The patient visited the Diabetes Clinic one month after discharge. She had discontinued the insulin and showed no glycosuria. Fasting blood sugar was 107. Five months later, a glucose tolerance showed:

	Mg. %
Fasting	103
½ hour	169
1 hour	190
2 hours	152

This was considered indicative of latent diabetes.

This patient developed marked hyperglycemia (700 milligrams per cent) during her first pregnancy which was complicated by a staphylococcus aureus septicemia. After termination of the pregnancy and recovery from infection, glucose tolerance became normal. During subsequent pregnancies she developed clinical manifestations of diabetes which were absent between pregnancies. She is now symptom-free without insulin but her sugar tolerance is impaired.

CASE TWO

A 41-year old woman, gravida 6, para 6, was admitted to the Medical Service of the Newark Beth Israel Hospital complaining of polydipsia, polyuria and pruritus vulvae. She was in the sixth month of pregnancy during which she had lost three and a half pounds. She had noted polydipsia, polyuria, polyphagia and some weight loss during each of her previous pregnancies. Between pregnancies, she gained weight and had no symptoms suggestive of diabetes. She had been informed during her first pregnancy that she had diabetes but she never took insulin and never adhered to a special diet. She had no other difficulties during her pregnancies or deliveries. All of her children were healthy. None weighed more than eight and a half pounds at birth. The records of previous admissions are summarized here.

First Pregnancy: Age 28. Diabetes discovered. No insulin. Baby's birthweight: 7 pounds.

Second Pregnancy: Age 30. Marked glycosuria noted in eighth month. Fasting blood sugar was 83, one month before term. Baby's birthweight: 6 pounds 11 ounces.

Third Pregnancy: Age 34. Glycosuria was first observed in the fifth month at which time the fasting blood sugar was 107. At the time of delivery it was noted that the patient was a "known diabetic well controlled by diet." Three days postpartum, fasting blood sugar was 120. Glucose tolerance curve eight days postpartum was:

	Blood Sugar	Urine Sugar
Fasting	79	Negative
½ hour	143	Negative
1 hour	231	1.5%
2 hours	231	3.3%
3 hours	176	2.8%

Fourth Pregnancy: Age 36. Glycosuria was first recorded during the fourth month. Fasting blood sugar at that time was 107. She delivered twin babies, one weighing 5 pounds and one 6. Postpartum glucose tolerance was:

Fasting	100
½ hour	150
1 hour	200
2 hours	250
3 hours	167

Fifth Pregnancy: Age 40. No data available.

Significant in the patient's history was the occurrence of diabetes in two maternal aunts and one brother.

Physical examination was essentially negative.

In the hospital the patient showed glycosuria and acetonuria. The blood sugar was 126. Carbon dioxide combining power was 35.

Glucose tolerance curve was:

Fasting	145
½ hour	220
1 hour	300
2 hours	320

All urine specimens contained sugar and acetone. The diabetic state was easily controlled with diet and 25 units of NPH insulin, the first insulin she had ever received. The new baby's birthweight was eight pounds ten ounces. The patient was discharged on diet and 15 units of NPH insulin. She visited the clinic two months after delivery, not pregnant, with all the clinical symptoms of diabetes. She was regulated with diet and 12 units of NPH insulin.

This patient developed symptoms of diabetes during each of six pregnancies. Impaired glucose tolerance was first tested for and found during the third pregnancy. During the sixth pregnancy insulin became necessary. The patient now has permanent clinical diabetes necessitating insulin.

CASE THREE

A 34-year old woman, gravida 8, para 7, was admitted in active labor to the Newark Beth Israel Hospital. In the Prenatal Clinic, increased blood pressure, edema, excessive weight gain and glycosuria had been discovered. She had refused earlier hospitalization. She has five living children. Also she had one stillborn and one baby died at eight weeks. No family history of diabetes was obtained.

The delivery was difficult. The shoulders could be delivered only after extensive lateral episiotomy. The baby, weighing 13½ pounds, was stillborn. Fasting blood sugar was 76 one day postpartum.

She did not return for 18 months. She was then near term again. She had been under the care of a private physician who detected diabetes and prescribed 70 units of insulin daily. Labor again was difficult, mid-forceps was used, the baby's shoulders were impacted and the cord prolapsed. The stillborn baby's weight was fourteen pounds. Postpartum blood sugars ranged from 72 to 158.

Only one dose of 15 units of regular insulin was given on the day after delivery. The patient returned once to the Diabetes Clinic, three weeks postpartum. She then reported polydipsia, frequency and nocturia which, as she stated, improved when she cut out sweets. She was recalled to the clinic 6 months later. There was no glycosuria. The fasting blood sugar then was 106. At this time, a glucose tolerance study showed a diabetic curve. However, she had no clinical symptoms of diabetes.

This patient was observed only during her eighth and ninth pregnancies, both of which ended with stillbirths of very large babies. Glycosuria was discovered during these two pregnancies. During the last one she required insulin. Postpartum she had several abnormally high fasting blood sugar readings. Five months postpartum she was asymptomatic but showed a diabetic glucose tolerance curve.

CASE FOUR

A 24-year old patient was first seen in the ninth month of her second pregnancy. She had increased hunger, polydipsia, frequency of urination and progressively marked nocturia almost since the beginning of pregnancy. Urine showed four plus sugar, no acetone. Fasting blood sugar was 190. She had one 2½ year old child. The previous pregnancy was uncomplicated, but the patient recalled that she had to drink more water than usual. She was unaware of diabetes at that time. The first baby's birthweight was six pounds eleven ounces. There was no known family history of diabetes.

The patient was hospitalized and treated with an 1800-calorie diabetes diet and 14 units of NPH insulin. There was continuous four plus glycosuria with only traces of acetone in occasional specimens. A week later, labor was induced and a baby weighing seven pounds twelve ounces delivered. A few hours after delivery and on the following days only traces of sugar were found in the urine. Fasting blood sugar tests, antepartum, showed 148 to 159 milligrams per cent. The postpartum figures were 122 and 135.

The patient did not return until six months after delivery. She had no symptoms suggestive of diabetes. Her weight had remained stable at about 149 pounds. Urine specimens were not obtained. At that time, glucose tolerance test with 100 Grams of glucose showed:

Fasting	142
½ hour	230
1 hour	269
2 hours	228

This patient was discovered to have diabetes towards the end of her second pregnancy. Symptoms suggestive of diabetes were observed during her first and second pregnancy. Insulin was given only until delivery.

Six months postpartum she was asymptomatic but showed a definitely diabetic glucose tolerance curve.

CASE FIVE

This is a 27-year old woman admitted at term. A few years ago, she had had a miscarriage in the fourth month. She was now approaching the end of her second pregnancy. Labor did not progress satisfactorily. An attempt at forceps delivery failed. The umbilical cord prolapsed and a cesarean section was performed. The baby was alive and weighed 12 pounds. Although the patient had not shown glycosuria during her pregnancy, the large size of the baby induced the obstetrician to have a glucose tolerance test done. The result was:

	Blood Sugar	Urinary Sugar
Fasting	115	None
½ hour	200	0.3%
2 hours	141	0.3%
3 hours	115	0.3%

She was re-admitted two years later in the fifth month of a third pregnancy. No glycosuria had been discovered during the preceding three months of observation. She had been nauseous for about three weeks. For three days before admission she was unable to retain any food. She was conscious on admission, but on the following day she became drowsy and lapsed into diabetic coma. Blood sugar was 400. Carbon dioxide combining power was 15 volumes per cent. She developed shock and oliguria. Three hundred sixty-five units of insulin were needed to get her diabetes regulated. The temperature rose to 103 degrees. Four days later, a macerated fetus was delivered. On the next day, she required 120 units of regular insulin. Two days later she was taking 80 units. Five days thereafter, she was discharged on 40 units of NPH insulin with a normal fasting blood sugar. The insulin dosage was gradually reduced and insulin was discontinued three months after delivery.

The following year, a therapeutic abortion was performed during which she showed no glycosuria. She is now pregnant again, and, so far, no glycosuria has been observed. Blood sugar tests were not performed.

This patient had one miscarriage and during her second pregnancy showed a diabetic glucose tolerance curve following the birth of an oversized baby.

The next pregnancy, during which she went into diabetic coma, ended in the birth of a five-month old dead fetus. Insulin was discontinued three months later and the patient was asymptomatic.

CASE SIX

A 40-year old diabetic was admitted for emergency operation of a ruptured ectopic pregnancy. Her mother is also a diabetic. The patient made an uneventful recovery from the operation and was discharged on an 1800-calorie diet and 40 units of NPH insulin.

She gave the following history.

First Pregnancy: Ended in stillbirth of a 14-pound baby.

Second Pregnancy: During the fourth month, diabetes was first discovered when the patient exhibited the classical symptoms. She was treated with diet only until the seventh month when she was hospitalized and put on 35 units of NPH insulin. Fasting blood sugars ranged from 198 to 125. A full term baby weighing eight pounds was born. Subsequently, the urines were sugar free and no more insulin was given.

Glucose tolerance test four days postpartum, showed:

Fasting	137
1½ hours	239
2 hours	333
2½ hours	315

The patient kept a prescribed diet without insulin for about one year. She was sugar free with normal fasting blood sugar levels on a totally unrestricted diet for 3 years. Then, during a period of vaginal bleeding, presumed to be caused by a miscarriage, she again developed diabetic symptoms and a fasting blood sugar of 282 was found. Since that time she has been on 45 units of insulin.

This last patient had a stillborn baby weighing 14 pounds. Two and a half years later, during her second pregnancy, she developed diabetic symptoms requiring insulin. Following termination of this pregnancy, she became asymptomatic for about four years. Then, manifest diabetes recurred and became permanent.

DISCUSSION

In all six cases, diabetes became manifest during pregnancy, especially in the second or third trimester, disappeared partly or com-

pletely following termination of the pregnancy and recurred with subsequent pregnancies. Finally permanent diabetes ensued.

When the first case of this series was observed showing a fasting blood sugar of 700 and, a few weeks postpartum, a normal glucose tolerance curve, we were unable to decide whether she should be labeled a true diabetic. Follow-up of this and the other five cases made us realize that we were dealing with patients who were either predestined to become diabetics, so-called "pre-diabetics" or who were individuals whose diabetic state was "latent," that is, too mild to produce clinical symptoms. In Case 5, the diabetes was discovered only through the alertness of the obstetrician who ordered a sugar tolerance test on a patient who had delivered a very large baby.

URINARY excretion of reducing substances is very common in pregnancy. Lactosuria is usually limited to the period of lactation or the last two weeks of pregnancy. Excretion of true glucose with normal blood sugar levels, so frequently observed during pregnancy, is caused by a "lowered renal threshold" *i.e.* impaired reabsorption of sugar by the renal tubules.

Fasting blood sugar levels may be normal, and only a tolerance test will bring out the first evidence of diabetes. It may not be feasible to do routine glucose tolerance tests on all pregnant women, but it seems likely that post-prandial blood sugar tests during the second and third trimester of pregnancy would bring to light a number of otherwise unrecognized cases of diabetes.

History of diabetes in the family and abnormal obstetrical histories, miscarriages, large babies, even the mother's own birth weight, if known, may justifiably make us suspicious and lead to the proper diagnosis. Hoet [1] who has pioneered in studying the diabetogenic action of pregnancy has emphasized that cases of diabetes mellitus may be detected *during pregnancy* many years before they become clinically manifest.

Repeated pregnancies may, however, hasten the development of permanent diabetes as illustrated in some of our cases. An interesting German observation [2] points in this direction. An instance is described in which one of a pair of monozygotic twins developed manifest diabetes following repeated pregnancies while the other was a latent diabetic discovered only by glucose tolerance tests.

A popular idea exists that in a pregnant patient with diabetes mellitus the growing fetus will supply sufficient amounts of insulin to alleviate the mother's diabetes. This theory has not been confirmed. White [3] states that the mother's insulin requirements may double or treble during pregnancy, and this has also been the case in our own experience. Postpartum in the diabetic as well as in the pre-diabetic mother, the sugar tolerance will most often return to the pre-pregnancy level. Thus, it seems that whatever hormonal stimulus produces diabetes in the pre-diabetic or aggravates an already established diabetes, does not last long enough to cause permanent breakdown of the carbohydrate metabolism.

In contrast to the ever increasing number of normal babies born to diabetic mothers (owing to meticulous prenatal care, adequate doses of insulin, hormones, and most important of all, delivery before term) the rate of fetal or neonatal deaths in our cases of pre-diabetics or latent diabetics is appalling. Of 26 pregnancies in the cases reported in this paper, 9 resulted in miscarriage, stillbirth or death in the first weeks of life. The obstetrical difficulties caused by the excessive size and weight of the babies such as the impaction of the "Herculean shoulders," as Benewitz [4] de-

1. Hoet, Joseph P.: *Diabetes*, 3:1 (January 1954).

2. Editorial in *Diabetes*, 5:150 (February 1956).

3. Joslin, E. P. and others: Treatment of Diabetes. Ed. 9. Philadelphia, 1952. Lea & Febiger.

4. A case report which fits into this grouping was published by Benewitz as far back as 1824. Priscilla White refers to it in her chapter in the 1952 edition of the Joslin 3 book. Benewitz's patient had four pregnancies. The first died at 14 weeks. The third was complicated by vaginal bleeding. At the start of her fourth pregnancy, she developed symptoms which we would today recognize as diabetic. When this pregnancy was successfully terminated, the diabetic symptoms disappeared, only to return during the fifth pregnancy at which time marked glycosuria was noted. During this delivery, great difficulty was encountered because the baby's shoulders were too big. The stillborn baby weighed 12 pounds. In describing this, Benewitz used the phrase, "you would surely say that Hercules had begotten him"—a phrase which has since become famous in this connection. Incidentally, the symptoms of diabetes subsided after the fifth pregnancy.

scribed them, gave rise to desperate situations. Four of our six patients delivered babies weighing between ten and fourteen pounds.

Eighty per cent of babies born of diabetic mothers are overweight. Hoet[1] emphasized that children of pre-diabetic mothers show an exaggerated development, over average weight and a "plethoric" appearance not unlike that of Cushing's syndrome. We can fully agree with this observation. Pathologically, cardio- and hepatomegaly and a conspicuous hyperplasia of the islets of Langerhans have been described.

Some controversy exists over the question of whether the birth of large babies may presage diabetes in the mothers. A number of authors have stated[5] that diabetic women frequently had large babies or abnormal obstetrical histories years prior to the onset of diabetes, a fact which has not been confirmed by others.[6] Our own experience teaches that, regardless of statistical chances, mothers of overweight babies should be investigated for diabetes. In view of the high infant mortality the pre-diabetic mother deserves as much attention as the diabetic mother. The obstetrician should be alerted to case findings, and, according to Hoet,[1] insulin should be given to all pre-diabetic mothers in the highest doses tolerated. The incidence of intra-uterine deaths during the last few weeks of gestation makes termination of the pregnancy about the 35th week advisable.

The significant hormonal changes occurring during pregnancy are likely to be implicated in the pre-diabetic mothers and their offspring. Corticosteroids in the peripheral blood, usually occurring in minute quantities, are markedly increased during pregnancy, reaching higher levels than those observed in Cushing's syndrome. Hoet[1] and Jailer[7] have found an increased response of the adrenal cortex to ACTH during pregnancy. Cortisone was found in the amniotic fluid only in diabetic mothers. The urinary excretion of corticosteroids postpartum is higher in diabetic than in non-diabetic mothers.

The Cushing-like appearance of the fetus points towards increased action of corticoid hormones. Hoet[1] has experimentally demonstrated the abortifacient action of cortisone. Fajans and Conn[8] have devised a test giving two doses of cortisone preceding a standard glucose tolerance test. With this "amplified" glucose tolerance test they have been able to detect diabetic tendencies in individuals, especially in members of diabetic families, who showed no abnormality in handling carbohydrates when tested with conventional methods. The assumption seems to us not too remote that pregnancy by the action of increased amounts of corticoid hormones acts as a "tolerance test" and brings latent cases of diabetes to light. That the additional stress of complications such as septicemia or a febrile disease could cause an explosive development of severe diabetes, is readily understood.

SUMMARY AND CONCLUSIONS

1. Cases of prediabetes or latent diabetes are described which became manifest during pregnancy, recurred during subsequent pregnancies and finally developed permanent diabetes.

2. The importance of early detection of diabetic tendencies in all cases of pregnancy is stressed.

3. The high fetal morbidity and mortality makes active treatment of the prediabetic mother imperative.

4. Hypercorticism probably causes the manifestation of diabetes during pregnancy in predisposed individuals.

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5. Miller, H. C.: New England Journal of Medicine, 233:376 (1945); *also* Kriss, J. and Futcher, P., Journal of Clinical Endocrinology, 8:380 (1948); *and* Paul, T. J., American Journal of Obstetrics and Gynecology, 71:70 (1956).

6. Dolger, H. and Herzstein, J.: Journal of the American Medical Association, 125:931 (1944).

7. Jailer, Joseph: Discussion, October 27,1955, before N. Y. Diabetes Association.

8. Fajans, S. S. and Conn, J. W.: *Diabetes*, 3:296 (1954).

Carl P. Guzzo, M.D.

Orange

Injuries of the Pancreas

Dr. Guzzo's essay on the anatomy, physiology, and diseases of the pancreas won the 1955 award of the New Jersey Anatomic and Pathologic Society. This paper is one part of that prize-winning essay.

Injuries of the pancreas may be classed as surgical or as accidental. Accidental injuries fall into two subclasses—penetrating and nonpenetrating. A gun shot wound with a bullet entering the pancreas would be an example of a penetrating wound. A forceful blow to the upper abdomen with no foreign body in pancreatic tissue would be an example of a nonpenetrating injury.

Surgical damage to the pancreas may occur in operations on the spleen, stomach, duodenum and left kidney or adrenal area.

Symptoms of pancreatic injury include pain in the epigastrium with radiation of pain to the left flank. Shock may be immediate or delayed, usually from massive bleeding. In mild injuries, the pain may be mild, intermittent for several days, and then become severe. The delayed appearance of hiccups is suggestive of pancreatic injury. Signs, including shock, cyanosis, dyspnea, tenderness, a rigid epigastrium or flank area may be great or minimal. The appearance of an expanding abdominal mass may be suggestive of pancreatic involvement following injury in this area. The mass may represent a hematoma, cyst, or abscess.

Increased serum and urinary amylase levels are reported. All patients with a severe upper abdominal trauma should have these enzyme studies. All patients operated on in the stomach, duodenum, spleen, common duct and left kidney areas should have these studies. All patients with upper abdominal complications should have amylase studies.

Treatment includes: immediate laparotomy, evacuation of hematoma or collected fluid, control of hemorrhage and suction drainage; drainage of secondary cysts; cysts may be marsupialized. Persistent fistulae should be treated by careful handling; that is by implantation of the duct of Wirsung with the jejunum and distal pancreatectomy of the fistula arising in the tail.

Injury to the pancreas can be minimized by careful handling. Intubation of the common bile duct may injure the pancreas if awkwardly done. Direct suture of the pancreas should be avoided, especially in the region of the main duct. If injury is definitely known to be present, immediate repair with pump suction drainage is required.

A man complained of an abdominal fistula three months after being kicked by a horse. There was a mass in the epigastric region. On exploration, the surgeon found a large hematoma. A persistent fistula developed, with a discharge of turbid, irritating fluid. The tract was mobilized and implanted into the jejunum. Four months later, he was again struck in the abdomen following which he had severe attacks of upper abdominal pain with nausea, vomiting and fever. The diagnosis was acute pancreatitis. From then on he had intermittent mild attacks, with one sudden severe attack.

Later in the clinic he appeared chronically ill. His abdomen was flat, but he had epigastric tenderness. At operation, we found adhesions. The mesenteric and omental veins were greatly dilated (4 times normal size). The entire pancreas was enlarged and indurated. A cyst was seen on the posterior pancreatic wall. The portal vein ran immediately beneath the thin posterior wall of the cyst. Distal pancreatectomy was done—tail, body and neck were removed. The symptoms vanished and relief was complete.

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Cerebral Apoplexy Associated with Pancreatic Carcinoma*

This is perhaps the first—surely one of the very few—cases of hemiplegia due to carcinoma of the pancreas. Dr. Kessler makes the point that obscure thrombo-embolism should always alert the doctor to the possibility of a pancreatic carcinoma. Since this malignancy produces no characteristic early signs, this is a particularly valuable suggestion.

Thrombophlebitis is not uncommon in patients suffering from visceral carcinoma. While any organ may be the primary site, this complication occurs more frequently with carcinoma of the pancreas than with any other organ. This is especially true if the body or tail of the pancreas is involved.

Sproul [1] found in 4,258 consecutive autopsies that in 56 per cent of the cases of carcinoma of the body or tail of the pancreas at least a single thrombus was present; in 31 per cent of these, widely disseminated venous thrombosis had occurred. She quotes Trousseau [2] as probably the first to mention the concomitant occurrence of thrombo-embolic manifestations with malignancy.

The thrombophlebitis accompanying carcinoma of the pancreas is often migrating or recurring, frequently multiple, involving especially the lower extremity without apparent cause. It may be observed before any other evidence of the underlying malignancy can be detected. Certainly carcinoma of the pancreas [3] should be suspected when thrombophlebitis occurs without known cause [4] especially in males between 40 and 70 years of age.

While numerous reports deal with thrombophlebitis in carcinoma of the pancreas, only two seem to mention venous and arterial thrombotic phenomena. Thompson and Rogers [5] in 157 autopsied cases of carcinoma of the pancreas break down the thrombo-embolic complications into four groups: (1) arterial embolism (pulmonary artery), (2) arterial thrombosis, (3) venous thrombosis and (4) infarctions. They found that 31 per cent of these showed thrombo-embolic phenomena. Half of these were single and the rest multiple. Buttross and Salatich [6] reported a 55-year old man with numerous episodes of arterial and venous thromboses who was subjected to many sympathetic blocks, sympathectomy and one amputation three months before an abdominal mass was palpable. Autopsy revealed a ductal carcinoma of the head of the pancreas with metastases to liver, lung

*This work is from the Medical Service of the Perth Amboy (N.J.) General Hospital.

1. Sproul, E. E.: Am. J. of Cancer 34:566 (1938)

2. Trousseau, A., quoted by Sproul[1]: Clin. méd. del' Hotel Dieu de Paris 3:80 (1877)

3. Ingelfinger, F. J.: New England J. Med. 235:653 (1946)

4. Durham, R. H.: Archives of Internal Medicine 96:380 (1955)

5. Thompson, C. M. and Rogers, L. R.: American Journal of the Medical Sciences 223:469 (1952)

6. Buttross, D., Jr. and Salatich, J.: Annals of Internal Medicine 43:213 (1955)

and periaortic nodes. In late stages nonbacterial fibrinous vegetations may develop on heart valves giving rise to superficial arterial or pulmonary emboli.[4]

The mechanism responsible for the thromboembolism is not clear. Platelet count, coagulation time, bleeding time and the bone marrow are normal in these cases. The thrombi do not contain malignant cells. Moolten and his associates[7] believe that an enzymatic product, thrombocytosin (which may be liberated by tissue breakdown of any type as in carcinoma) may develop platelet adhesiveness causing endothelial "wettability" and intravascular platelet coagulation. In carcinoma of the pancreas this reaction may be accelerated and enhanced by higher levels of pancreatic lipase which can be found increased in about 50 per cent of all cases. Endothelial "wettability" and platelet adhesiveness are the principal governing factors in thrombosis.

Moser and his group[8] say that an increased concentration of trypsin in the blood may increase its coagulability causing thrombophlebitis.

Reported here is a case of carcinoma of the tail of the pancreas. It is unique insofar as the first severe manifestation of the underlying disease was a cerebrovascular accident caused by cerebral arterial thrombosis producing the typical picture of left hemiplegia.

A 34-year old man was admitted to Perth Amboy General Hospital on July 22, 1955. Four weeks prior to admission he had noticed pain in the right lower leg which was diagnosed as "strained muscle" and treated with hot packs and exercise. Later his left leg was similarly involved but this time the condition was considered a "swollen vein." The pain in the legs never quite left him and he also had slight fever, diminished appetite and lost some weight. However, he continued working until the morning of July 22, 1955 when, after getting out of bed, he collapsed and found himself unable to move his left arm and leg. He had never experienced abdominal discomfort, weakness or backache. He was a very moderate drinker and smoker. Family and past history were irrelevant.

Physical examination: The patient was a fairly well developed and well nourished 34 year old white man with flaccid paralysis of his left arm and left leg and partial paresis of the left facial nerve. Speech was thick and nasal, and the neck was stiff. The eyes deviated to the right and the pupils reacted to light sluggishly. The patellar and Achilles tendon reflexes were normal on the right and absent on the left. Abdominal reflexes were positive on the right but missing on the left. Babinski and Oppenheim were positive on the left side only. Heart, lungs, pulse, blood pressure, and abdominal palpation were all normal. Fundi were normal. There was no lymphadenopathy. Examination of the remaining systems showed no abnormalities.

Hemoglobin was 72 per cent. Red cells numbered 4,000,000 per cubic millimeter; white cells 15,000 per cubic millimeter with 89 per cent granulocytes and 11 per cent lymphocytes. The erythrocyte sedimentation rate was 26 millimeters per hour. Repeated urine studies revealed a trace of albumin and a specific gravity of 1020. Urine was otherwise normal. Sugar was never present. He had a fasting blood sugar of 102, blood urea nitrogen 18 and nonprotein nitrogen 43.

Cerebrospinal fluid pressure was 270 millimeters. The fluid showed normal reduction for sugar and contained normal amounts of protein and chlorides. In this fluid, we found 20 white cells per cubic millimeter and many red cells. A later spinal fluid examination revealed similar values with only 4 white cells per cubic millimeter. Colloidal gold reaction and Mazzini test for syphilis were negative.

The day after admission, he had a complete spastic left hemiplegia with ankle clonus. Conjugate deviation was unchanged, the sensorium was less clear and he had more trouble swallowing. Temperature was slightly elevated. He received glucose witth vitamin B and Ringer's solution intravenously and also was given penicillin and streptomycin intramuscularly. A Foley catheter was inserted. X-ray of the skull revealed no roentgenologic evidence of increased intercranial pressure.

On the third hospital day, he felt better. Sensorium was clearer and he responded to simple questions. The neurologic condition was unchanged. On the fourth day, however, there was increased rigidity of all extremities. Eyes were fixed in midline. Pupils were narrow and did not react to light. Babinski and Oppenheim were positive bilaterally. Breathing was laborious. These symptoms suggested involvement of the pons. He fell into coma and died on the sixth hospital day, July 27, 1955.

The history of fever about four weeks prior to admission suggested an inflammatory etiology. Right cerebral abscess or tuberculous meningitis were considered as possibilities. The patient had been admitted at the peak of the poliomyelitis season. Spastic hemiplegia (which is extremely rare in this condition, although it may occur with encephalitis) was

7. Moolten, S. E., Vroman, L., Vroman, G. M. S. and Goodman, B.: Archives of Internal Medicine 84:667 (1949)

8. Moser, R. A., Rosenak, B. D. and Pierce, W. J.: A Test for Coagulability of the Blood in Carcinoma of the Pancreas. Paper presented at the 1954 session of the American Gastro-Enterologic Association.

considered and dismissed. Acute multiple sclerosis with hemiplegia is very unusual. The sudden occurrence of hemiplegia suggested a vascular etiology, although there was no apparent basis for cerebral embolism or thrombosis. As the patient had not complained of headache, had not vomited and had not lost consciousness, the possibility of cerebral hemorrhage was dismissed. The most likely diagnosis seemed to be thrombotic encephalomalacia involving the right hemisphere of the brain and more recently the pons.

The positive findings in the autopsy report are listed below.

The pial and arachnoid vessels are engorged. There is extensive encephalomalacia, involving the right parietal area. This encephalomalacia has destroyed the corpus striatum and the internal and external capsules. There is thrombotic occlusion of the right middle cerebral artery. Sections reveal softening and multiple small hemorrhages within the pons. Another area of softening is found at the base of the left occipital lobe.

Both lungs are boggy. On cut sections, the lungs appear dark purple-red in color and show many areas of hemorrhagic infarction. Bronchi have red mucosa and show bloody exudate. In the heart, there is noticed an area of advanced atherosclerosis of the descending interventricular branch of the left coronary. Each cusp of the aortic valve shows soft reddish granular vegetation along the line of closure. The other valves are free and unimpaired. Endocardium, myocardium, large vesseis, trachea and esophagus are grossly unimpaired.

Abdomen: Scattered hemorrhages are noted within the lower omentum, the pelvic cavity and retroperitoneally. The spleen reveals hemorrhagic infarction. The liver is studded with multiple yellowish-white infiltrations which appear umbilicated on the surface. Cut section reveals scattered granular soft malignant infiltrations. The gastrointestinal tract is grossly unimpaired. The tail of the pancreas reveals extensive adhesions to surrounding structures and an irregular hard mass is felt within it. Multiple sections reveal a firm yellowish-white irregular tumor which has destroyed the tail of the pancreas. Both kidneys reveal infarctions. The mesentery and retroperitoneal spaces also show infarctions and hemorrhages.

MICROSCOPIC PATHOLOGY

Pancreas: (Multiple sections)—Adenocarcinoma (Duct carcinoma). Areas of necrosis.

Liver: Metastatic adenocarcinoma. Focal necrosis. Passive hyperemia.

Kidney: Hyperemia. Parenchymatous degeneration. Hemorrhagic infarction.

Brain: Infarction and encephalomalacia.

Summary: Scirrhous carcinoma of tail of pancreas with metastases to regional lymph nodes and liver and associated with multiple thromboses involving cerebral vessels, pulmonary vessels, splenic vessels, renal vessels, mesenteric, omental and retroperitoneal vessels.

SUMMARY

REPORTED here is an unusual, possibly unique case in which thrombi and emboli caused by pancreatic carcinoma produced an encephalomalacia with hemiplegia. This patient had never before been seriously ill. He first developed "phlebitis" in one leg and three weeks later sustained a "stroke" and was hospitalized. He died on the sixth day after admission. Autopsy revealed carcinoma of the tail of the pancreas with extensive metastases and multiple thrombo-embolic lesions the most impressive of which was cerebral arterial occlusion causing hemiplegia. The patient had never displayed any signs or symptoms of pancreatic disease.

The diagnosis of carcinoma of the body or tail of the pancreas[9] is notoriously difficult.[10] Not infrequently no other signs or symptoms suggesting malignancy are observed at the time of the accompanying thrombo-embolism. Finding such thrombo-embolism, arterial or venous, in a patient with an obscure illness should raise the suspicion of pancreatic carcinoma.

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9. Berk, J. E.: Journal of Oklahoma Medical Association 43:143 (1950)

10. Wilbur, D. L.: Modern Medicine Annual, Special article on Pancreatic Carcinoma, 1956, page 103.

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Administrative Aspects of Blood Procurement*

Last November, The Medical Society sponsored a blood bank seminar. This is one of the papers delivered at that round-up of blood-banking information.

Blood occupies a unique position among therapeutic agents in that it must ultimately be obtained from human beings. Unlike all other drugs and biologicals, its supply to the distributor depends upon adequate motivation of the source. The source is an unpredictable creature called man. Thus, the administrative aspects of blood procurement may be divided into two broad categories; (1) organization and interrelationships of involved agencies, and (2) donor recruitment.

THE BLOOD BANK

The basic agency is the blood bank. This is a medical facility designed, equipped, and staffed to procure, draw, process, store, and distribute human whole blood or its derivatives.† A true blood bank should be able to function as a complete unit without relying on other institutions to handle one or more of these services. A regional blood bank and its participating hospital blood banks constitute a geographic and administrative entity known as the "Regional Blood Program."

A hospital blood bank is operated by a hospital primarily to serve its own needs and occasionally those of other hospitals in the area. It is the ultimate unit in the regional program. Its director is legally and morally responsible for the total supply of blood to his institution. In this capacity, he is interested in all available sources. He is much less concerned with who gets the credit than with who gets the blood. He offers a 24-hour phlebotomy and processing service which cannot be approached by most regional banks. The director has a direct awareness of the problems presented by that most important but sometimes most forgotten cog in the whole administrative machine: the patient.

A regional blood bank is usually a nonprofit facility locally organized and controlled to serve the needs of the hospitals in that community. It is a relatively large organization committed to a single activity. As a result, the operating cost may be considerably lessened by procedural streamlining and bulk purchasing. It is usually equipped with one or more mobile units which open up sources of blood frequently closed to the hospital blood bank. This is particularly true in industry where the blood may be collected as an on-the-job operation. Its multiple hospital affiliations allow it effectively to buffer excesses in both supply and demand. Occasionally, it is a clearing house for exchange of "credits" among participating hospitals. More often it serves to transport blood directly from one institution to another. It is usually physically and admin-

*Read by invitation November 2, 1956 before the Blood Bank Seminar, Presbyterian Hospital, Newark, N. J. Part of the material in this paper was published in the New England Journal of Medicine 255:739 (1956) and part of it was published in the May 1955 issue of The Modern Hospital.

†Definition adopted by the American Association of Blood Banks.

istratively independent of the participating hospitals.

Regional blood banks may be sponsored by any agency, but the two major sponsors are the medical society and the American Red Cross. No matter who the sponsoring agency is, adequate administrative liaison between the hospital and regional banks is of vital importance to the success of the program. Where such liaison does not exist, regional banks have made unrealistic commitments which cannot be fulfilled and have adopted a somewhat cavalier attitude towards hospital banks. Conversely, hospital banks have, for reasons of economic or administrative superiority, obstructed the development of regional banks. This has led to ill will, unfavorable publicity, and an air of hostility which operates to the detriment of both agencies involved.

IN THE Red Cross sponsored system, administrative control is usually exercised by a committee of the state medical society. The effectiveness of this control depends upon the organization of the committee and the backing given it by the medical society. The problems under the Red Cross system are multiple and seem to be increasing. In areas where the program is established, it seems the prudent course to attempt their solution. In areas where the program is not established, it seems unwise to become involved in any system which may increase the difficulties and decrease the possibilities of their resolution.

County or state medical society sponsorship avoids many of the administrative problems of the Red Cross program. Occasionally, however, a regional blood bank may be set up without the cooperation of (or even in opposition to) the hospital blood bank directors. As a result, its administrative policies may not reflect the best interest of the hospital blood banks or even of the program as a whole. Hospital blood banks should be well represented on the governing boards of their affiliating regional blood banks. Such representation should be in the category of full voting membership. With regard to contracts between hospital and regional blood banks, all hospital representatives must clearly recognize the implications and potential problems inherent in such agreements. They must be entirely satisfied that the contract is realistic and workable. They must be prepared to meet the administrative and technical standards involved. Above all, they should not commit themselves so heavily to a single agency that their local reserves and processing facilities suffer an atrophy of disuse. A significant number of contracts are so phrased that the hospital blood bank is dependent solely upon the regional bank with no provision for failure of the regional bank to meet its obligations.

If a regional program does not include a regional bank, the constituent hospitals must have the closest of liaison with respect to the interchange of blood. While this is usually carried on as a direct interhospital function, it may at times be desirable for one of the participating hospital banks to assume the functions of a regional bank. This not only facilitates blood interchange, but allows the region to enjoy the advantages of centralized administration and standardized technics. At the same time it obviates the necessity of setting up a new physical unit with all of its financial and administrative difficulties.

If no type of regional bank seems desirable, it may be advisable for the hospitals of the region to set up a clearing house. While clearing houses usually operate on a larger scale, they can be of considerable value on a metropolitan or county basis. A clearing house is a central bookkeeping agency created and supported by allied blood banks to provide the following basic services:

1. To handle the exchange of donor replacements between blood banks.
2. To keep records, balance accounts, and arrange settlements to cancel inter-bank indebtedness.
3. To facilitate the borrowing and lending of blood between banks wherever and whenever needed.
4. To engage in such auxiliary services as are best conducted through a central agency, such as a registry for rare blood groups, a central focus for defense blood procurement, and so forth.

The clearing house is not a blood bank. It is strictly a bookkeeping agency for the exchange of blood debits and credits in a city, a state, or throughout the country.

Such a program is being nationally encouraged by the American Association of Blood Banks. It is hoped that eventually the national clearing house program will enable anyone in any part of the United States to deposit a unit of blood as credit against a transfusion in any other part of the United States, much in the fashion that money deposited in your local bank can, by the medium of a written check, proceed through a clearing house and establish credit with any business throughout the country. Such a program has certain inherent difficulties but is eminently worthy of support by all blood bankers.

The administrative structure of blood banking in New Jersey is almost exclusively a function of the medical societies, county and state. The organizational plan should follow closely that of the parent society. Each county may be construed as a regional program under the guidance of the county medical society blood bank committee. The regional programs should be integrated into a state program under the aegis of the Blood Bank Commission of The Medical Society of New Jersey. Such a plan has been recommended by the Blood Bank Commission and adopted by the Board of Trustees of The Medical Society of New Jersey. Two matters for consideration emerge from this already accepted plan. First, is medical society sponsorship and guidance enough or should some all-inclusive organization (like the New England Association of Blood Bank Directors) be instituted? Second, what are the precise functions, spheres of authority, and policy responsibilities of the county versus the state medical societies?

Concerning the first, it would be a grave error to bring into being any organization which might work at cross purposes to the already established administrative structure. Such an organization could, however, serve a valuable purpose as an educational forum in both the technical and administrative aspects of blood banking. Education of the laity would do much to improve public relations and as a result improve donor recruitment. Education of the profession would go far in stopping the unwise or even unnecessary use of blood. It was shown by Lesses and Banton[1] in a comparison between Massachusetts and Connecticut hospitals that the number of transfusions given was almost exclusively a function of the availability of the blood rather than the state of the patient. It has been demonstrated by Freeman[2] in radioisotope blood volume studies of severely ill patients that some 50 per cent had a normal whole blood, plasma, and cell volume regardless of their hematocrit, hemoglobin, or red count. Only 12 per cent had a deficiency and 27 per cent were hypervolemic. It seems naive for us to be so concerned with blood procurement and never question its use. Perhaps an organized and aggressive policy of education backed by some rules and regulations would solve many of our administrative problems at their source.

On the problem of state versus county authority, certain details need clarification. What should be the composition of the county medical society blood bank committee? What are the functions of this committee? What are its relationships with the blood banks of the county? To what extent will regional decisions influence state policies? Are the general policies which are essential for an integrated state program to be formulated at the county level and passed up, are they to be formulated at the state level and passed down, or should a broader committee with regional representation be set up?

The regional program is the basic unit in blood procurement. The organization of this unit is almost exclusively a function of the community involved. What works well in one area may fail in another. Successful programs

1. Lesses, M. F. and Barton, H. J.: Use of Blood in Massachusetts Hospitals. New Eng. J. Med. 253:24 (1955)
2. Freeman, W.: A Major Transfusion Hazard: Overloading the Circulating Blood Volume. The Sixth Congress of the International Society of Blood Transfusion in conjunction with the Ninth Annual Meeting of the American Association of Blood Banks, Page 48 (1956)

cannot be transplanted. Each region must analyze its needs and potentialities in terms of its own social and economic structure. No small amount of the strife which has beset blood banking over the past decade has resulted from one regional group trying to impose its policies on another regional group, either directly or through a higher administrative echelon. It must be clearly delineated what policies are to be instituted at a state level for the best interest of all regions and what policies are to be strictly regional. Once this has been decided upon, regional policies must stay regional.

NATIONAL ORGANIZATION

ATTEMPTS to produce administrative cohesion at the regional or state levels have until recently been more or less frustrated by apathy on the part of the national medical organizations involved. At the time the American Red Cross instituted its civilian blood procurement program, the national societies which might reasonably have been expected to provide strong administrative control were the American Medical Association, the American Society of Clinical Pathologists, and the American Hospital Association. They chose, however, to adopt a "middle-of-the-road" policy. This resulted from the fact that blood banks were not widely represented in any of these groups and it seemed unwise to commit the societies as a whole to any active policy. Obviously, some organization was needed to produce administrative and technical unity, and the American Association of Blood Banks was founded in 1947. Over the ensuing nine years this organization has expanded to the point where it now occupies an important position among the other interested organizations. It carries tremendous weight inherent in the fact that it is composed exclusively of blood bankers and devoted solely to blood banking.

In spite of the existence of this vigorous new colleague and in the face of rising regional and state difficulties, the national organizations continued their policy of "no active participation." Finally the absolute necessity of providing a national mechanism for the resolution of these rapidly mounting problems became obvious to all concerned and in 1953 the House of Delegates of the American Medical Association passed the Ludwig Resolution which called for "the establishment of a coordinated national blood program operated by the American Medical Association, the American National Red Cross, and other qualified organizations interested in blood banking." The original resolution has now been developed into a Joint Blood Council including representation from the American Association of Blood Banks, the American Hospital Association, the American Medical Association, the American National Red Cross, and the American Society of Clinical Pathologists.

CHARITY, SWEET CHARITY

WHILE the organizational aspects of blood bank administration are of paramount importance, economic considerations must not be overlooked. Although most blood banks are incorporated as charitable institutions, there seems to be misunderstanding of the precise meaning of this phrase. The original concept of a "charitable institution" dates back to 1601 when the English Parliament in the reign of Queen Elizabeth enacted the *Statute of Charitable Uses*. This was replaced in 1888 by the current act. In this country, today, the designation of an institution as "charitable" finds its chief significance in the fields of income tax and malpractice litigation. From the court decisions, it is obvious that operating a blood bank on sound business principles in no way jeopardizes its standing as a "charitable" institution. Here are some judicial opinions: "That patients able to pay are required to do so does not change the fundamental nature—." "The test of a charitable institution is not the extent of the free services rendered nor whether the patients pay more or less cost for the services, but whether those who operate it are doing so for private profit, directly or indirectly."[3] Charity, even

in its broadest sense, means the providing of services for those who are unable to provide for themselves. It does not mean the provision of free services for all, regardless of ability to pay.

Contributing to this confusion of charity with socialism is the notion that blood has some mystic quality which raises it above mundane cash considerations. Regardless of one's private philosophy, it is a fact that blood banking is a business and must be run as such. Failure to do so courts disaster, no matter how noble the motives.

Perhaps the most pernicious aspect of this misconception is the protective cloak which it throws over incompetence and inefficiency. A loose concept of "charity" is conducive to loose cost accounting, unwise investments, and improper conservation of resources. Any charitable blood bank must be able successfully to meet commercial competition. Although charitable banks (in contradistinction to commercial banks) absorb all uncollectable debts, these should not much exceed 20 per cent of the gross charges. In addition, a charitable bank obtains most of its blood without cost, whereas a commercial bank pays the bulk of its donors. When private charity is no longer available, county or state tax funds may be looked to for support. If this situation develops, the private practice of medicine has lost one more outpost to political control. While profiteering in blood is to be vigorously condemned, sound fiscal thinking in blood banking is highly recommended.

DONOR RECRUITMENT

THE success of a well-organized blood program depends largely on the cooperation of the residents in the area served. In the beginning, at least, cooperation is largely a matter of education and "salesmanship." Because of the relative importance of administrative problems, there is sometimes a tendency to "sell" people on the agency rather than on the product. The agency involved should be of no immediate concern to the participants. Under no circumstance should intramural differences be allowed to influence donor recruitment.

Donors are recruited from two main groups: (1) the public as a whole, and (2) the friends and relatives of recipients. The general public donates either as a charitable gesture or as a deposit against future needs by the donor or his immediate family. The extent to which such contributions become an insurance depends upon the nature and scope of the program under consideration. Insurance commitments must be very carefully analyzed before being put into operation. Donations from friends and relatives of recipients usually constitute either a deposit against a known future demand or a replacement of blood already given.

While policies concerning recruitment involve both the hospital and regional blood banks, the mechanics of recruitment may be a function of either or both agencies. Successful donor recruitment is a function of the compulsion which leads people to donate. In some programs this consists of an economic penalty. In others it assumes the nature of a moral obligation. Motivation produced by economic penalty is simple, straightforward and highly effective. A cash charge is made for the blood and this charge is canceled upon the donation of an appropriate amount within the time specified. Moral obligation, in contradistinction, is a complicated and elusive force. Properly utilized, however, it is more effective than economic penalty. It is fostered by vigorous publicity, aggressive campaigning, and door-to-door solicitation. Its success, however, is in large part a function of the cultural, economic and social status of the community. Group competition in sponsoring donor drives may strengthen the general feeling of obligation and desirability of participation. But this competition is healthy only when all groups are recruiting for a single program. If "splinter" recruitment agencies are allowed to operate for a select few, the program is headed for disaster. Splinter groups must be brought in under the aegis of the community program.

3. Hayt, E., Hayt, E. R. and Groeschal, A. H.: Law of Hospital, Physician and Patients. New York, Hospital Textbook Company, 1952. Ed. 2

This is not always easy, since suspicion, resentment, and intense personal pride must be overcome. As with the administrative organization of the agencies, the problems of each group are unique and their solution is frequently time consuming. The amalgamation of such groups into a single unit, however, is well worth the effort.

Most donors are bled directly in the regional or hospital banks. However, the importance of an adequate walking donor list cannot be over-emphasized. The walking donor fills large unscheduled requests, particularly for rare types. The walking donor provides fresh blood for cases of thrombocytopenia and hemophilia. The walking donor is locally available on short notice in the middle of the night. Prospective walking donors should be clearly informed of their obligations, typed and catalogued. The file should be kept at a convenient location which has 24-hour coverage. Special attention should be paid to rare groups, and such donors should not be bled except upon demand. The availability of walking donors may spell the difference between success or failure in a crisis. Their recruitment should be aggressively pursued by all facilities available.

CONCLUSION

THE successful implementation of blood procurement policies at the regional or local level is almost exclusively a function of the social, economic, and political environment at that level. To produce functional efficiency, all participating agencies must operate within the administrative boundaries of these policies. Without such regulations, the clearing of debits and credits between local hospitals would be awkward, between one region and another difficult, and at the national level impossible. A similar situation applies to technical problems. While acceptable technics may vary widely, there are certain minimum standards which must be complied with. Failure to meet such standards presents a real obstacle to the physical interchange of blood.

It is our ultimate goal to formulate policies and develop standards of blood banking for New Jersey. If it is borne in mind that we are concerned with broad general principles, that local problems are best settled at local level, and that a free interchange of blood can be arrived at only by the acceptance of generally established regulations, our common aims will be accomplished with efficiency, dispatch, and good will.

Hackensack Hospital

Health Facts

Voluntary health insurance now pays more than 25 per cent of the total annual expenses for all personal health services incurred by both insured and uninsured persons in this country, Health Information Foundation reports.

In the past eight years, the proportion of the nation's total medical expenses met by voluntary health insurance has increased three times as fast as the proportion of Americans holding such insurance, according to Health Information Foundation.

According to Health Information Foundation, the average American incurred total charges of $71.50 for medical care and services in 1956. In the same year, the average person covered by voluntary health insurance received benefits of $27.

The American people spent more than $11.8 billion for personal health services during 1956, Health Information Foundation reports. More than 25 per cent of this sum, or almost $3 billion, was covered by voluntary health insurance.

Sanitary Regulations Really Work*

Since the International Sanitary Code went into effect in 1952, not a single epidemic of the old quarantinable diseases has occurred as a result of international travel. The traditional diseases in this group are cholera, typhus, smallpox, yellow fever and the bubonic plague. It is against these great plagues of history that quarantine measures have been chiefly applied, both in the past and under the present International Sanitary Regulations of WHO. This code provides measures essential against the quarantinable diseases which cause the least possible obstruction to international traffic. Since 1952, only 45 ships and one aircraft in all the world have been reported as infected (*i.e.* carrying a person suspected of suffering from one of the quarantinable diseases).

Not only have the Regulations proved satisfactory during the first four years of their existence, but "the spirit in which they are being applied bears evidence of a desire for mutual cooperation, understanding and goodwill."

CHOLERA

Although cholera has been endemic for centuries in India and China, no westward movement of the disease occurred until the 19th century when six huge epidemic waves spread to nearly all parts of the world.

Since World War II, the disease has made only brief excursions outside its central Asian stronghold. It appeared in Japan in 1946, in Egypt and Syria in 1947 and Indochina in 1952. In recent years, cholera has dwindled in importance to the point of being a problem only in its endemic foci in India and Pakistan. Elsewhere, cholera has disappeared.

The declining importance of cholera throughout the world is attributed almost entirely to better sanitary conditions in all countries which make it difficult for the infection to take hold. International transport by its nature is now unlikely to spread the infection.

PLAGUE

The first record of a plague pandemic dates from the 6th century A.D., in the time of the Emperor Justinian. It was described as "one of the worst calamities that ever befell mankind." In the 14th century the notorious Black Death killed millions of people in Europe and Asia and brought organized human society almost to an end. This second visitation lasted nearly 200 years.

Another pandemic started in China in 1850 and was spread by maritime traffic to ports and countries all around the globe. The "plague spots" which continue to exist even today in parts of Asia, Africa and the Americas, are remnants of the epidemics of the last century. The present outlook is bright, however, and the disease in its human form has declined significantly. General sanitary improvement has contributed to this situation and the new insecticides and rodenticides have helped reduce the threat of infection.

TYPHUS

Epidemic typhus is transmitted by the body-louse, and has a calamitous record throughout the ages as the grim companion of war, famine and castastrophe. It was expected to flare up again during World War II, but actually never got out of hand. Although there were serious outbreaks in North Africa, Yugoslavia and Korea, they did not disorganize whole communities as in the past. Today, typhus is disappearing from Europe and decreasing in Africa, except Ethiopia where a large number of cases was reported in 1955. Until 1953, some of the countries of Latin America were still recording significant numbers of cases. In the Pacific area, the only serious outbreak in recent years was in Korea and resulted from war conditions. From the point of view of international travel, typhus retains little importance today.

SMALLPOX

All epochs, regions, climates and peoples have known smallpox. History, even up to very recent times, tells the sad story of its destructive effects. The situation tends to improve, however.

For the past five years, 58 per cent of all cases were reported from India and Pakistan,

*Abstracted from the October 1956 issue of the *Chronicle of the World Health Organization.*

23 per cent from other countries of Asia, 14 per cent from Africa south of the Sahara, and 5 per cent from Latin America. The fact that severe smallpox is now confined to certain endemic areas of the globe is evidence of the dramatic decrease in this scourge. The persistence of endemic foci requires vigilance to prevent the infection from spreading elsewhere. But smallpox is no longer the threat it used to be even at the beginning of this century.

YELLOW FEVER

A disease of tropical Africa and America, yellow fever has in the past been known to invade Europe and North Africa, but has *never* spread to Asia. This is an epidemiologic mystery, and one of the major considerations in present quarantine practice concerning this disease.

After centuries during which outbreaks of "yellow jack" periodically spread panic in two continents, and was a continual hindrance to the development of new areas, the disease has today been restricted to a definable position. Thanks to mosquito eradication campaigns and widespread vaccination, control of yellow fever has now been successful over large areas.

THE PROSPECT

Certain trends are clearly discernible with regard to the quarantinable diseases: *cholera* should be "eliminated within the not too distant future"; *plague* is no longer a problem in international traffic, but there must be "no lowering of sanitary requirements for ships and ports, no relaxation of efforts to keep ships and warehouses free from rats"; *relapsing fever and typhus* are now of little concern and the regulations which apply to them are almost never used; *smallpox* "continues to be a nuisance" in international quarantine practice, but even this highly infectious disease is receding . . . and should soon "join the other diseases which are passing from the active quarantine scene"; *yellow fever* is the most serious problem in international quarantine; the fears of Asian countries concerning possible importation of this disease are legitimate, but there is cause for optimism in the success obtained in the Americas, which shows that the disease can be suppressed from urban areas.

The irresistible size and significance of rapidly growing world transport will make the application of old-fashioned quarantine technics of little avail. Today there is too frequent use of isolation and quarantine measures against international travelers in the name of controlling infections such as influenza, poliomyelitis, and others. Such diseases may remain "quarantine" problems for some time; but it is doubtful if the present type of international sanitary regulations should ever be extended to them.

ACS Tumor Clinics in N. J.

The New Jersey Division of the American Cancer Society since its incorporation in 1945, has made noteworthy progress in the establishment of cancer clinics throughout our state. In 1945, there were 11 clinics. At the end of one brief decade, 42 clinics were in operation in 18 of New Jersey's 21 counties.

In this report, subsidies paid by the American Cancer Society to approved clinics in New Jersey for the most recent three consecutive years, 1952-53, 1953-54, and 1954-55, were arranged in a table by counties. Amounts shown for each clinic represent money paid for visits and diagnostic service together. It is assumed that the amount of subsidy is a fair measure of the activity of a clinic under the terms of *Part 4—The Cancer Program in New Jersey*.

For the purpose of providing a quick summary of the *trend of activity* in a clinic or a group of clinics within a county, a system of relative numbers is used. These numbers appear in various combinations of 1-2-3 in the column headed *Activity Pattern*, such as 321, 213, *etc.* In combination, they show *trend* alone and do not reflect quantity or quality of service. The first year used—1952-53 — is taken for a base year and the activity of a clinic in the next two years to be relative to the base year. For example: A clinic is designated 213. This means activity dropped in the second year but picked up in the third year, surpassing its activity in the base year. The combinations follow:

123	Increase each year
213	Increase and highest year
312	Increase but not highest year
132	Decrease but not lowest year
231	Decrease and lowest year
321	Decrease each year

This method is not sensitive to large or small changes, and *does not indicate volume of activity*. For example, a clinic might have a high level of activity showing little fluctuation from year to year and yet be assigned 321.

TUMOR CLINIC ACTIVITY BY COUNTIES FOR THE THREE-YEAR PERIOD 1952-53 TO 1954-55 INCLUSIVE

Each hospital at the beginning of each year is given a basic grant of $520. Allowances of $2.50 for each first visit and $1.00 for subsequent visits as reported by the clinics are applied against the grant. In addition, allowances are made for certain diagnostic procedures. Amounts shown below are those actually earned by the clinics and amounts over $520. include the basic grant.

	1952-53	1953-54	1954-55	Activity Pattern
ATLANTIC COUNTY				
Atlantic City Hospital	$2,217	$3,327	$1,499	231
	$2,217	$3,327	$1,499	231
BERGEN COUNTY				
Englewood Hospital	$ 318	$ 238	$ 582	213
Hackensack Hospital	464	910	1,304	123
Holy Name Hospital	82	78	25	321
	$ 864	$1,226	$1,911	123
BURLINGTON COUNTY				
Burlington County Hospital	$1,989	$1,792	$1,640	321
	$1,989	$1,792	$1,640	321
CAMDEN COUNTY				
Cooper Hospital	$1,579	$2,133	$2,138	123
West Jersey Hospital	1,564	1,877	1,654	132
	$3,143	$4,010	$3,792	132
CAPE MAY COUNTY				
Tomlin Memorial Hospital	$ 702	$ 978	$1,176	123
	$ 702	$ 978	$1,176	123
CUMBERLAND COUNTY				
Bridgeton Hospital	$1,103	$ 765	$1,394	213
Newcomb Hospital	858	549	44	321
Millville Hospital	....	....	239	X
	$1,961	$1,314	$1,677	312
ESSEX COUNTY				
Beth Israel Hospital	$2,586	$2,404	$1,721	321
East Orange General	710	1,126	612	231
Mountainside Hospital	....	524	413	...
Presbyterian Hospital	2,740	5,060	4,756	132
St. Barnabas Hospital	540	204	268	312
St. Michael's Hospital	2,142	1,830	3,389	213
Irvington Gen. Hospital	52	....	....	X
	$8,770	$11,148	$11,159	123
GLOUCESTER COUNTY				
Underwood Hospital	$ 93	$ 71	$ 292	213
	$ 93	$ 71	$ 292	213
HUDSON COUNTY				
Christ Hospital	$1,286	$ 504	$ 677	312
North Hudson Hospital	834	88	123	312
St. Mary's Hospital	413	385	292	321
	$2,533	$ 977	$1,092	312
HUNTERDON COUNTY				
Medical Center	....	$ 638	$ 271	X
		$ 638	$ 271	X
MERCER COUNTY				
Mercer Hospital	$ 522	$ 538	$ 724	123
McKinley Hospital	85	261	227	132
St. Francis Hospital	1,240	1,490	1,328	132
Princeton Hospital	13	22	292	123
	$1,860	$2,311	$2,571	123
MIDDLESEX COUNTY				
Perth Amboy General	$ 236	$ 758	$ 818	123
	$ 236	$ 758	$ 818	123
MONMOUTH COUNTY				
Monmouth Memorial Hospital	$1,821	$1,124	$ 990	321
Fitkin Memorial Hospital	637	1,088	1,119	123
	$2,458	$2,212	$2,109	321
MORRIS COUNTY				
All Souls Hospital	$ 935	$1,069	$ 922	231
Dover Gen. Hospital	749	538	299	321
Morristown Memorial	1,005	819	733	321
	$2,689	$2,426	$1,954	321
OCEAN COUNTY	....	....	....	X
PASSAIC COUNTY				
Barnert Hospital	$ 920	$ 606	$ 414	321
Passaic General	271	234	142	321
Paterson General	2,118	1,632	1,932	312
St. Joseph Hospital	1,192	1,063	1,280	213
St. Mary's Hospital	336	654	582	132
	$4,837	$4,189	$4,350	312
SALEM COUNTY				
Salem Memorial Hospital	$ 121	$ 210	$ 56	231
	$ 121	$ 210	$ 56	231
SUSSEX COUNTY				
Newton Hospital	....	....	$ 590	X
			$ 590	X
UNION COUNTY				
Elizabeth Gen. Hospital	$5,508	$5,283	$5,155	321
Muhlenberg Hospital	304	188	193	312
	781	306	213	321
	$6,593	$5,777	$5,561	321
WARREN COUNTY	....	....	....	X
TOTAL ALL CLINICS	$41,066	$43,364	$42,518	132

SUMMARY OF CLINIC ACTIVITY PATTERNS

Activity Pattern	No. of Clinics	No. of Counties
123	7	5
213	5	1
312	5	3
132	5	1
231	4	2
321	12	4
X*	5	5
132 (All)	43	21

*Under clinics, number of clinics not in operation for three consecutive years. Under counties, a county with clinics not in operation for three consecutive years.

The discrepancy of 43 clinics in the table and 42 clinics referred to earlier is due to the fact that Irvington General Hospital Clinic suspended operation pending re-organization. It is included in the summary.

Clinic activity shows a decrease in 1954-55 in 21 clinics with reference to the base year 1952-53; in 21 clinics again in comparison with 1953-54; and in 26 clinics in one year or the other. Thus it appears that in 26 clinics now in operation, *more referrals could be handled with present facilities* without establishing additional clinics in these areas.

Ten counties reflected a decrease in the same manner. This, of course, is in terms of the total clinics within a county, and including clinics which had increases not off-setting the diminished activity of others in the same county.

In general, rather than look to the establishment of additional clinics at this time, the activity pattern in some counties seems to indicate that some effort should be made to bring the clinics reporting decreasing activity up to at least their previous high level marks. It is not assumed that those clinics which report increased activity could not handle more cases with more promotion.

Is there a formula based on population and the cancer problem in certain areas, which would justify establishing a minimum number of clinics to serve the state adequately? Population is not a single important factor. It assumes that demand for such clinics is at its maximum in all areas and that the clinics would be used by physicians everywhere at an optimum. Perhaps we can look forward to the day when we can say, "so many people or so many cancer cases require so many clinics."

There are no cancer clinic facilities in Ocean, Warren and Somerset. Approval of the organization of a clinic in Warren County is pending. It is generally agreed that there should be at least one cancer clinic in each county.

In Ocean County, the 1950 population was 57,000. It is estimated that this county's population will soar to 90,000 or better by 1960, or an increase of over 57 per cent. Its 1955 cancer deaths were 163. It is reported that Ocean County attracts many retired people who will take up their residence there. This will no doubt be reflected in a rising cancer population more than in other growing counties which are attracting younger-age groups, such as Burlington. If Ocean County residents were to use clinics in bordering counties, the distances traveled to the nearest clinics from the geographic center of Ocean County would be: Atlantic City—41 miles; Mt. Holly—26 miles. Neptune—26 miles. These factors would indicate the need for a clinic in Ocean County.

Warren County's 1955 cancer deaths were 110. Its 1950 population was 54,500 with an estimated increase to 58,500 in 1960.

Somerset County's 1955 cancer deaths were 159. Its 1950 population was 99,900 with an estimated increase to 139,500 (40%) in 1960.

Middlesex County has one clinic in Perth Amboy. The population of Perth Amboy in 1950 was 41,300. In 1955, cancer deaths were 99. There would appear to be justification for a clinic in New Brunswick, the other larger population area—38,800 — with 1955 cancer deaths of 74. The Perth Amboy Clinic's activity pattern shows increased use of its facilities over three consecutive years. Population of Middlesex County (1950) was 267,000 with estimated increase to 347,000 in 1960.

Cancer deaths in 1955 in Middlesex County were 568. This county had the greatest increase in cancer deaths: 108 more than in the previous year.

CONCLUSIONS

The New Jersey Division should adopt a conservative attitude toward the establishment of additional cancer clinics in areas where there are already facilities. In general, present clinics could carry a larger load if referrals increase. With few exceptions, clinics operate on a one-session-a-week basis, and it would be more economical to increase the number of sessions than to establish another clinic. It would seem more practical to anticipate an increase in subsidy payments than to buy the additional equipment necessary to open a new clinic.

There appears to be a need for at least one clinic in each county. Efforts to establish cancer clinics in Ocean, Warren and Somerset counties are certainly justified.

More promotion of the use of the cancer clinics now established is indicated. This would be in the way of interesting more and more physicians in the clinics. The New Jersey Division's new program, *MD-Cancer*, will certainly have long-range results in this direction.

A policy of conservatism does not preclude clinics being set up in hospitals where there is good evidence of enthusiastic support by the hospital and its doctors and where the establishment of such clinics would not be a duplication of facilities within an area.

Obituaries

DR. HAROLD C. BENJAMIN

The Seton Hall College of Medicine faculty suffered its second loss by death on March 29, 1957, when Dr. Harold C. Benjamin, professor of orthopedics, died. Dr. Gerald Cetrulo, the Assistant Dean, had been fatally stricken only a month before. Dr. Benjamin was born in Jersey City in 1898 and received his M.D. from Bellevue in 1921. He was an orthopedist affiliated with most of the hospitals in Hudson County. He suffered his fatal coronary attack while actually doing a surgical operation at the Jersey City Medical Center, where he was Director of Orthopedics. Dr. Benjamin was active in the affairs of the New Jersey Orthopedic and the Hudson County Medical Societies. He was supervising surgeon to the A. Harry Moore School, a special school for disabled children.

DR. GERALD I. CETRULO

On March 10, death prematurely brought to a close one of New Jersey's most promising medical careers. Long a spark-plug in graduate medical education here, Dr. Gerald I. Cetrulo died of a heart attack at the Idlewild Airport while standing at a counter arranging transportation to Newark. He was only 49 years old at the time of his death. Born in Newark, Gerald Cetrulo was graduated from Bellevue in 1931 and interned at the Clara Maas Hospital in Newark. He was attending surgeon at both the Columbus Hospital and Clara Maas, and was an F.A.C.S. Dr. Cetrulo was Assistant Dean at the Seton Hall College of Medicine, Assistant Superintendent of the Martland Medical Center, a State Commander of American Veterans of World War II (and a national vice commander of that organization) and President of the New Jersey Progressive Council.

Dr. Cetrulo was long-term chairman of graduate medical education for the Essex County Medical Society. He was a pioneer in developing graduate medical courses at Seton Hall. His prime hobby was fencing, and he was one of the best known fencers in the United States. He was a former national AAU fencing champion. Some years ago, he was a member of our country's Olympic fencing team. He was President of the New Jersey Amateur Fencers' League. Dr. Cetrulo was also medical director of Newark Civil Defense. It is doubtful if any 49-year old doctor in the state has made so many varied contributions to his profession and his community.

DR. ARTHUR EWENS

Dr. Arthur Ewens, formerly of Atlantic City, died in Cooper Hospital, Camden, following a sudden illness. He was 75.

Dr. Ewens had practiced medicine in Atlantic City 50 years before going to live with a daughter in Haddonfield last year. He belonged to the Elks, Lions and Masons in Atlantic City. He was a graduate of Johns Hopkins University and the University of Maryland.

Although Dr. Ewens was for many years a general practitioner, his particular field of interest was nose and throat surgery and he served for a time as chief of surgery at the Atlantic City Hospital. He was known especially for his interest in the function of the uvula and surgical correction of deformities of that tissue. He had written extensively on the subject of staphylectomy and some of his papers were published in journals abroad.

DR. JOHN B. FAISON

Dr. John B. Faison died on March 11, 1957 at the age of 61. A 1925 graduate of the medical school of the University of Virginia, Dr. Faison devoted himself to oncology and radiology. He was a diplomate of the American Board of Roentgenology and a Fellow of the American Radium Society. He was affiliated with all the hospitals in Jersey City, and was a consulting tumor surgeon at St. Mary's Hospital in Hoboken. Dr. Faison, a Princeton alumnus, served in the Navy in World War I and was active in Princeton alumni affairs in New Jersey.

DR. I. HAROLD FRANKLIN

On January 26, 1957 Dr. I. Harold Franklin died suddenly at the age of 66. Dr. Franklin was born in Jersey City and received his M.D. from the College of Physicians and Surgeons at Columbia University in 1912. After interning in New York he returned to his native city to establish a general practice. He served the people of Hudson County from 1913 until his retirement in 1955. Dr. Franklin was particularly interested in surgery and at the time of his retirement was chief of surgery at the Fairmount Hospital.

DR. HARRY N. GOLDING

Paterson lost its senior radiologist on March 16, 1957, with the death on that day of Dr. Harry N. Golding. Born in Canada in 1883, he was brought to Paterson in childhood. In 1906 he received his M.D. at Cornell. He then interned in Long Island and returned to Paterson to enter private practice in 1908. He became a pioneer in radiology and was St. Joseph Hospital's first chief of roentgenology. He became a diplomate in that specialty with the establishment of the Board. A Fellow of the American College of Radiology, Dr. Golding was affiliated, at one time or another, with most of the hospitals in the Paterson-Montclair area.

DR. HALVOR L. HARLEY

At the age of 74, Dr. Halvor L. Harley died suddenly, and quietly, in his sleep on March 16, 1957. Born in Laurelton, N. J. in 1883, Dr. Harley was graduated in 1908 from the old Medico-Chirurgical College of Philadelphia. After an internship in Trenton, he settled in Pleasantville, New Jersey, and served the people of Atlantic County for almost half a century thereafter. He did general practice until his Army service in World War I. Thereafter he became increasingly interested in ophthalmology, and in 1920 closed his office to do 3 years of intensive graduate work in that specialty. He was one of the earliest diplomates of the American Board of Ophthalmology. He was historian of the Atlantic County Medical Society, coroner of the county, and president of the Pleasantville Board of Education. He was also the first chairman of the Ophthalmology Section of our Society. Dr. Harley was also known locally as a poet and collector of Americana.

DR. ERNEST E. JOHNSON

At the untimely age of 41, Dr. Ernest E. Johnson, one of Passaic County's most promising surgeons died on April 11, 1957. Born in Passaic, Dr. Johnson was graduated in 1942 from the medical school at Syracuse. He returned to his native state for internship, serving on the house staff at the Jersey City Medical Center in 1942-43. After a tour of duty as an Army surgeon, he accepted a surgical residency at the Jersey City Medical Center and, in 1946, entered private practice in Passaic. He was active in the Academy of Medicine, in the Passaic County Medical Society and the International College of Surgeons. Dr. Johnson was one of the state's few physician-airplane pilots and was a member of both the National Aeronautical Association and the New Jersey Pilot's Association. Dr. Johnson was affiliated with American Veterans of World War II. He was on the surgical staff of the Passaic General Hospital.

DR. PHILIP MARVEL, JR.

Dr. Philip Marvel, Jr., an Atlantic City cardiologist, was found dead in his automobile on February 23, 1957. Dr. Marvel was 65 years old at the time of his death. He was graduated in 1917 from the Medical School of the University of Pennsylvania and the following year moved to Atlantic City. He was the founder and first chief of the cardiology clinic of the Atlantic City Hospital and for some years was president of the Atlantic County Heart Association.

DR. JACOB M. SILVERSTEIN

Dr. Jacob M. Silverstein died of a heart attack on March 3, 1957 while on a cruise off Haiti. Dr. Silverstein was born in England in 1900 and was taken to Millburn, N. J. as an infant. In 1925 he was graduated from the Medical School of the University of Maryland and returned to Millburn after his internship. He served the people of Millburn and vicinity for thirty years. He was for many years police surgeon and was active in civic and religious affairs in that city. Dr. Silverstein was a general practitioner, particularly interested in gastroenterology, and was on the staff of the Irvington General Hospital.

Announcements • • •

Golf Tourney for MDs

The American Medical Golfing Association will hold its tournament June 3, 1957 at the Westchester Country Club, Rye, New York. It is a championship layout with two eighteen hole courses, a Beach Club on Long Island Sound, tennis courts and even a polo field.

Eighteen hole competition will determine championships and will be the basis for the awarding of prizes.

The Westchester Country Club is thirty miles from Grand Central Station. It is easily reached. Golfers wishing to have quarters closer to the Club can secure reservations at nearby hotels in Rye or Harrison, N. Y.

Tournament play will start at 8:30 a.m. Players may tee-off up to 2:00 p.m. Buffet luncheon, banquet, prizes and green fees are included in the day's activities. The banquet will be served promptly at 7:00 p.m. followed by awarding of prizes. All male members of the American Medical Association are eligible to participate. Get further details from Robert Elwell, 3101 Collingwood Blvd., Toledo 10, Ohio.

Calling Maryland Alumni

On June 5, 1957, during the AMA convention, Maryland alumni are being received at a cocktail party (Dutch treat) between 5 and 7 p.m. at the New York Coliseum.

Pennsylvania Accepts N. J. Premarital Certificate

Pennsylvania has amended its premarital law to permit New Jersey physicians to sign premarital examination certificates.

The New Jersey form may be used if the Pennsylvania form is not available.

A complement fixation test, as well as a standard flocculation test, is required in Pennsylvania.

Seton Hall Faculty

The following appointments to the Faculty of the Seton Hall College of Medicine were made by Monsignor John L. McNulty, President of Seton Hall University and Dr. Charles L. Brown, Dean of Seton Hall College of Medicine, effective March 1, 1957:

Dr. Earl J. Halligan, professor of surgery and Associate Dean
Dr. Thomas J. White, professor of medicine
Dr. Harold C. Benjamin, professor of orthopedics
Dr. Edward N. Bookrajian, professor of gynecology
Dr. Milton G. Borrone, professor of otorhinolaryngology
Dr. Frank Bortone, professor of thoracic surgery
Dr. Francis X. Brophy, professor of ophthalmology
Dr. Samuel A. Cosgrove, professor of obstetrics
Dr. Edmund J. Daly, professor of urology
Dr. Francesco A. Figurelli, professor of psychiatry
Dr. William J. Gleeson, professor of anesthesiology
Dr. Louis L. Perkel, professor of gastroenterology
Dr. Harry J. Perlberg, professor of radiology

Congress on Maternal Care

A review of complete maternity care will be presented at the Congress on Maternal Care at the Palmer House, Chicago, July 8 to 12, 1957.

The five-day Congress will present topics dealing with the interprofessional approach to maternal and infant care. The Committee has developed a program to afford maximum opportunity for audience participation.

Speakers and registrants at the panel discussions, luncheons, round tables, breakfast conferences and Laymen's Forum will examine and pursue the questions: "What is Complete Maternity Care," Who Provides It," "How is Care Provided,"

Further information is obtained from The American Committee on Maternal Welfare, 116 South Michigan Avenue, Chicago 3, Illinois.

Handy Guide to Psychiatric Words

The country's oldest nationwide specialty society has finally done what all large medical societies have been talking about. It has released a book which translates psychiatric lingo into plain English. Called *A Psychiatric Glossary*, the book is issued by the American Psychiatric Association. It may be obtained postpaid by sending a dollar to that Association at 1785 Massachusetts Ave., N. W., Washington, 6, D. C.

Do You Check for Diabetes?

The State Department of Health reports that during Diabetes Detection Week, a physician in Cumberland County routinely tested for diabetes 97 patients who visited his office. Nine showed excess sugar. Three were diagnosed as diabetic and placed under treatment. That's just about three per cent.

Mailing Blood Specimens

During the summer months, blood specimens mailed to the Laboratory of the State Department of Health for serologic tests are subjected to the added hazards of high temperature and contamination. In order to avoid the embarrassment and delay incident to collecting repeated blood specimens from patients, physicians are asked to: (1) mail specimens as early in the week as possible, so that there will be no weekend or holiday lay-overs; (2) keep specimens in refrigerator until they are mailed and (3) take specimens with sterile dry needle and syringe to avoid contamination and hemolysis. These directions are always applicable, but especially during the summer months.

Martland Prize Winner

The Essex County Pathological and Anatomical Society announces that Herbert J. Schaeffer, M.D. has won the annual Harrison Stanford Martland Award for 1956. Dr. Schaeffer, a resident in pathology at the Overlook Hospital, Summit, presented his paper "Adenomatoid Tumors of the Epididymis" at the annual meeting of the Society on February 26.

The award comprising a gift of $250 and an engrossed scroll is presented each year by the Essex County Pathological and Anatomical Society as a memorial to Harrison S. Martland, M.D.

Urine Analysis Film Available

Without charge to physicians there is available a film entitled "Urine Sugar Analysis for Diabetics." This is prepared by the Ames Company and explains in language suitable for the layman the relationship between sugar, insulin and diabetes. The film is of 16 millimeter gauge and it has a sound track. Running time is ten minutes. The film may be obtained without charge by writing to the Ames Company at Elkhart, Indiana.

Cancer Films Available

The New Jersey Division of the American Cancer Society announces the availability of a large number of films suitable for both professional and lay audiences on various aspects of cancer. Some are colored; some are black and white. Some are sound films; most are silent films. A catalog may be obtained by writing to the American Cancer Society, New Jersey Division, 9 Clinton Street, Newark 2, N. J.

Letters to The Journal • • •

To the Editor:

I have been asked to comment on the filler "Vaccine Therapy—2 Edged Sword," which appeared on page 591 of the JOURNAL of The Medical Society of New Jersey (Dec. 1956). This questions the value of bacterial vaccine therapy in infectious bronchial asthma. If one uses autogenous bacterial vaccine, many reactions occur with doubtful therapeutic value. However, the stock vaccines in the last few years have given much better results and the tendency of most allergists today is to use stock vaccines rather than autogenous ones. Twenty years ago, most of us used autogenous vaccines.

Dr. William P. Buffum, one of our best pediatric allergists, writing about asthma in the first year, says, ". . . Usually stock vaccines are used, often a so-called mixed catarrhal vaccine, which is available commercially; almost all practitioners have found the stock vaccine surprisingly successful." (JOURNAL, Medical Society of N. J. 50:508; Nov. 1953.)

Even for a stock vaccine there is no recommended dosage. One must start with an extremely high dilution and work up slowly. It is a good idea to tell the patient that starting with such small doses, it may take at least five or six injections before any benefit will result, but reactions will be avoided.

Sincerely yours,

FRANK L. ROSEN, M.D.

Dear Sir:

The interesting item on "Responsibility in the Use of X-rays" is a timely one. Certainly with the expanding use of x-rays and radioactive substances in medicine and industry, the protection of our population against harmful radiation exposure is becoming a problem of increasing importance.

In well regulated radiology departments, scrupulous calibration of equipment, the wearing of exposure meters and proper records of individual exposure to radiation are now routine procedures. Also definite standards and limits of safe exposure are now well established.

However, education on the proper and safe use of x-ray equipment in medical practice can no longer be limited to the specialist in radiology. All those using x-ray equipment or radioactive substances must receive guidance in the proper methods required for the protection of themselves, their patients, and technical personnel. In certain places, the pollution of our atmosphere by a too heavy concentration of industry, has already produced hazards like smog. Shall we soon witness the addition of harmful radioactive dusts to our already polluted atmosphere?

The control of excessive radiation exposure in medicine and industry must be of immediate concern to the medical profession and all our Public Health services, on the local, state and national levels.

LOUIS J. LEVINSON, M.D.

Dear Sir:

The item on doctors' responsibility in the use of x-rays attracted my attention. I certainly agree that it is on you and on me and on all of us in the medical profession that this responsibility is placed. All of us, individually, share in the proper selection of patients for radiation procedures, diagnostic or therapeutic. Members of the profession, specializing in the application of radiation for diagnosis and therapy, are further charged with the responsibility of keeping radiation to the patient, to the technician and to the doctor optimal: the least amount of radiation possible to all involved to produce the proper, efficient medical use.

Physicians working with radiation must be charged further to employ their creative imagination and ingenuity to improve the medical effectiveness of radiation and to decrease the amount of radiation exposure. The science of electronics has great potentials in many fields of endeavor; let its application to the use of radiation be explored to the nth degree of completeness!

JOHN J. THOMPSON, M.D.

County Society Reports • • •

Atlantic

The regular monthly meeting of the *Medical Society of Atlantic County* was held at the Children's Seashore House, February 9. The President, Dr. Baxter Timberlake, presided.

Harry F. Zinssir, M.D., Associate Professor of Clinical Medicine, University of Pennsylvania, spoke on rheumatic heart disease.

The discussion was opened by Dr. Walker. Other discussors included: Dr. Shavelson, Dr. Peter Marvel and Dr. Rieck. All expressed their appreciation of the fine lecture.

The business meeting was opened by the reading of resolutions in memory of Dr. Arthur Edward Ewens and Dr. Joseph R. Weintrob.

The members stood in silence in memory of the two members.

Dr. Leach gave a short report of the financial condition of the Society.

Dr. Erber read a letter that had been sent to the press, telephone company and the police to remind them of the method by which a doctor is obtained in an emergency. Dr. Timberlake related the efficient way in which a doctor was available and responded in response to an emergency call in a car accident. It was recommended that a schedule be published in the Bulletin each month giving the dates when doctors are on call.

Dr. Mason, Jr., reported on the "Golden Age Club." He moved that the Society approve this club, but the motion did not pass as it was considered beyond the Society's area of interest.

Dr. Nickman moved that the following statement be sent to the State Board of Examiners:

> We, the members of the Medical Society of Atlantic County, are thoroughly cognizant of the circumstances surrounding the conviction of Dr. Albert J. Battaglia for violation of federal laws regulating the use of narcotic drugs. We do not condone the illegal act or advocate ignoring of the mandate of the law.
>
> We believe that Dr. Battaglia has suffered grievously, both emotionally and professionally, as a result of his misdeed.
>
> We hold Dr. Battaglia in the highest professional and personal esteem, and are convinced that there is no future danger of his failing to fulfill properly his responsibilities to his patients, his colleagues, or his government.
>
> We therefore, plead that the State Board of Medical Examiners give this case every consideration that lies within their power.

All present at the meeting started signing immediately, as an indication of the sympathetic feeling of the members.

Dr. Rostin White reported that at the State level there has been cooperation between the Medical Society and the legislators. The national report was less encouraging. The A.M.A. has not been successful in preventing the passage of many bills.

A letter was received calling attention to the problem of Hungarian refugee physicians. It was moved and passed that the Society donate $100 to the worthy cause.

Dr. Wilson and Dr. Molitch were named to the Community Council on Health.

Dr. Molitch moved that a microprojector be bought for the Society at the price of $1,250. After remarks by Dr. Nickman against such a motion, it was passed.

The regular monthly meeting of the *Medical Society of Atlantic County* was held at the Children's Seashore House on March 8. The President, Dr. Baxter Timberlake, presided.

Our guest speaker was Dr. Ernst Rogahn, one of our exchange physicians on the house staff of the Atlantic City Hospital. Dr. Rogahn was president of the student body of the University Medical School at the Freie University in Berlin. Dr. Rogahn spoke on "Berlin Today from a Medical Student's Viewpoint." He concluded his talk by showing 30 pictures of various interesting buildings, avenues, and sites in the German capital.

Dr. Max Gross reported his attendance at a meeting of the newly organized Community Homemaker Service for Atlantic County. This nonprofit Community agency places competent women, specially trained for the work, in homes disrupted or overburdened by illness. The Society then went on record as a sponsoring group for the Community Homemaker Service for Atlantic County.

A letter from Dr. Albert J. Battaglia was read in which he expressed his gratefulness and appreciation for the considerate and sympathetic understanding of our members, who have done so much in his behalf.

On Dr. Diskan's motion, a Budget Committee was created which would consider any request from our Society for any amount of money over $100.

The high spot and feature of our meeting was the presentation of the Annual Gold Medal *Bulletin* Award to the outstanding non-medical person who has done the most to promote the medical welfare of our community. This year Dr. Diskan, our *Bulletin* editor, had the pleasure of presenting pins to two distinguished gentlemen, Judge Leon Leonard and Judge George Naame. These outstanding local jurists accepted the awards as a token of the Society's regard for them. It was pointed out that these medals were going to an Arab and a Jew who have been closely associated with each other for many years, and that it was an example worthy of note in these troubled times.

The meeting was adjourned at 10:50 p.m.

LEONARD B. ERBER, M.D.

Reporter

Bergen

Approximately 175 invited guests and 110 physicians attended the February meeting of the *Bergen County Medical Society* to hear experts discuss "Your Role in the Control of Local Disasters." They represented more than half of the communities in the county.

Two staff members of the Army Institute of Research at Walter Reed Hospital, Col. Joseph R. Shaeffer, Chief of the Department of Atomic Casualties Studies and Lt. Col. Joseph D. Goldstein, Assistant Chief, were the speakers.

With the help of a film and slides, they painted a graphic picture of what an atomic bomb does when it explodes and described the only course of action possible for the population to avoid maximum injury. The Bergen County Medical Society hopes this exceptional meeting will serve as an initial step to combat the wide public apathy in Civil Defense in the county.

Before the meeting was turned over to Dr. Reuben M. Anderson, Chairman of the Civil Defense-Disaster Control Committee of the Society, the members elected to membership William M. Griffin, of Hackensack, William H. Cantwell of Rutherford, Francis P. Salvatore of Englewood, Balbina Bregman of Edgewater, Francis Pfaff of Teaneck and to Emeritus membership William K. Harryman of Hackensack. Reinstated to regular membership from a long residency was Wilson D. Webb, Jr., of Maywood. The report of the nominating committee placing in nomination delegates and alternates in the class of 1957-59 and the nomination of delegate and alternate to the nominating committee to The Medical Society of New Jersey were received and filed. An election of this slate will take place at the March meeting.

At its meeting at Bergen Pines County Hospital Tuesday evening, March 12, the *Bergen County Medical Society* elected 12 delegates and 12 alternate delegates to represent the Society at the 1957 Annual Meeting. Delegates are: Drs. Winton H. Johnson and Charles P. Campbell, Hackensack; Drs. Albert W. Cloud, G. Barton Barlow, George Heller and Walter Wahrenberger of Englewood; Rufus Little, Paramus; E. E. Jacobitti, Maywood; John P. O'Connor and Frank S. White, Teaneck; Richard P. Keating, Ridgewood; and Leo J. Fitzpatrick, West Englewood. Alternate delegates are: Richard B. Berlin, Raymond Saigh and Thomas J. Sperber of Teaneck; Ralph Gilady, Edith Williams and Herbert R. Mores, Hackensack; D'Arcy C. Clarie, Leonia; Newton H. Gresser, West Englewood; Istvan Gaspar, Englewood; Stanley E. Prentice, Tenafly; Raymond E. Banta, Ridgewood and Anthony M. Susinno, Palisades Park. Delegate to the State Society Nominating Committee for 1957 only is Dr. G. Barton Barlow of Englewood, and his alternate is Dr. F. G. Dilger of Hackensack.

Seven new Bergen County physicians were accepted as members and two were elevated from Associate to Regular status. The new members are: Dr. Selma Mitchel of Paramus and Dr. Mary Robinson Richards of Tenafly as Associates. Regular membership was granted to Dr. Melvin B. Robbins of Fair Lawn and Dr. Mary B. Slifer of Ridgewood, both formerly Associate members. Other elections were; to regular from courtesy status, Dr. Eugene V. Resnick of Teaneck; to regular by transfer from New York County Society, Dr. John P. Bruckner of Englewood; to regular on return from military service, Dr. Edward L. Liva of Ridgewood; and to Courtesy Membership Drs. Ralph A. Deterling of Tenafly and Martin H. Perle of Cliffside Park.

Two resolutions were sent to The Medical Society of New Jersey for presentation to the House of Delegates.

The speaker was Dr. Ralph Colp, Professor of Clinical Surgery, New York Medical College. Dr. Colp presented a paper on "Regional Ileitis" which was superbly delivered, and evoked a lively question and answer period. Following the scientific session, the meeting was adjourned and a collation enjoyed.

CHARLES P. CAMPBELL, M.D.

Reporter

Camden

The regular monthly meeting of the *Camden County Medical Society* convened March 5, in the meeting room of the Society with Dr. George P. Meyer, presiding.

The scientific program consisted of a panel discussion on general practice topics as well as the relationship of the general practitioner to other fellow practitioners. The panel consisted of Drs. Georgia E. Allen, George W. Harmon, I. Edward Ornof, Edwin Rosner and John K. Thomas. Dr. Frederick W. Durham acted as moderator.

Dr. Maldeis, member of the History Committee, reviewed the subscription blank for the biographical book now being compiled and urged all members to subscribe.

Dr. Harold D. Barnshaw was appointed chairman for the annual outing with the provision that he appoint his own committee.

Dr. Elmer Grimes suggested that younger members accept positions in the school systems in order that they may not be totally filled by the osteopaths. Dr. Dickensheets, Chairman of the Public Health Committee, gave the report of his committee concerning Salk vaccine. Dr. Harold Eynon urged the members of the Camden County Medical Society to participate in their municipalities' poliomyelitis vaccination clinics wherein only eligible persons, *i.e.* (those up to 18 years and pregnant women) would be given free vaccine where free vaccine was being used.

EUGENE H. KAIN, M.D.

Reporter

Cumberland

The regular meeting of the *Cumberland County Medical Society* was held at the American Legion Hall, Millville, February 12, with the president, Dr. Sherman Garrison, presiding. There were 49 members present.

Drs. Richard Edward Beck, of Millville, Harry A. Caplan, Vineland, George T. Varga, George H. Huston and John H. Yeamon of Bridgeton were unanimously voted to active membership in the society.

Dr. Albert B. Kump, of Bridgeton, President-elect of The Medical Society of New Jersey, reported on the prospective changes in the constitution of the state medical society.

Dr. Charles E. Sharp, of Port Norris, reported on bills pending in the state legislature regarding organized medicine.

Dr. Frank Aitken, past president of the Society and chairman of the Welfare Committee, presented each member with a pamphlet containing the names of all the agencies in New Jersey interested in the physically handicapped and indigent patients. The completeness of this brochure indicated a great deal of work by Dr. Aitken and the committee.

Dr. Sidney Siegel, chairman of the Diabetes Committee, read a letter from Dr. Krosnick, state coordinator of the Diabetes Detection Drive, in which the specific work of Dr. Paul Ayars, of Port Norris, was highly commended. He also stated that the final statistical data had not been compiled and he would give a final report at the next regular meeting.

The speaker for the day was Dr. A. Henry Clagett, Jr., a Delaware cardiologist who was obtained through the cooperation of the Cumberland County Heart Association. He was introduced by Dr. Frank Aitken, president of the Cumberland County Heart Association.

Dr. Clagett's paper was on the treatment of coronary heart disease. Its absorbing interest marked it as one of the finest educational presentations since the inception of the Heart Association.

LEONARD G. SCOTT, M.D.

Reporter

Middlesex

Dr. Sidney D. Becker, President, called the February 20, 1957 meeting to order at 9 p.m.

Dr. Slobodien, Chairman of the Judicial Medical Ethics Committee reported approval of the application for transfer to regular membership from the Los Angeles County Medical Association of Dr. Norman Karr of Milltown. This was unanimously endorsed by the society.

The Nominating Committee will consist again of Dr. B. F. Slobodien, chairman and Drs. M. M. Dunham and W. E. Sherman. The president announced that the Trustees had recommended that the "May Meeting" be a Dinner-Dance. There will be a regular meeting in June when newly elected officers will be installed.

Dr. Howard Slobodien was selected as alternate delegate to fill the vacancy left by the death of Dr. Mangogna.

Dr. Charles Brown, Dean of Seton Hall College of Medicine and Dentistry, then gave an extremely interesting and learned discussion on "Hypotensive Agents."

Dr. B. F. Slobodien, then reported that the Society was 75 members short of having a sufficient number to receive Medical-Surgical coverage on a group basis. A new drive will be opened to secure this number. Anyone desiring an application may secure it from Dr. George J. Kohut, or the office secretary.

A communication was received from The Medical Society of New Jersey informing us that chiropractors are legally qualified to sign disability claims. Dr. Becker reported that the Board of Trustees had approved an expenditure of $500 for the County Medical Society at The Medical Society of New Jersey Annual 1957 Convention. It is planned to have a cocktail party.

The monthly meeting of the *Middlesex County Medical Society* was convened at the Roosevelt Hospital, Metuchen, on March 20, at 9:10 p.m., with the president, Dr. S. D. Becker, in the chair. Dr. B. F. Slobodien, Chairman of the Judicial-Medical Ethics Committee reported applications as outlined below, which were unanimously approved by the Society:

To regular membership by transfer from Bergen County Medical Society: Dr. Alfred E. Greenwald, New Brunswick, sponsored by Drs. S. David Miller and L. Krafchik.

To regular membership by transfer from the Oneida County of New York Medical Society: Dr. Surgis A. Koroljow, New Brunswick, sponsored by Drs. Isabel M. London, H. Park, and J. F. Sandella.

To regular membership from associate membership: Dr. Irving Luftman, New Brunswick, sponsored by Drs. L. Lifschutz and N. Rosenberg; Dr. Robert J. Zullo, New Brunswick, sponsored by Drs. A. J. Barbano and J. F. Sandella. To two-year associate membership: Dr. Maria G. Koroljow, New Brunswick, sponsored by Drs. Isabel London and J. Sandella.

The president then announced that there was a change in the 1957 Nominating Committee to Dr. Stanley A. Gadek, Chairman and Drs. E. J. Brezenski and J. F. Sandella.

Dr. Breslow submitted a report from the Public Relations experts with whom he has been dealing. They quote specific figures which will be reviewed. A definite recommendation will be made at the next meeting.

This was followed by an interesting lecture by Dr. Arthur Blakemore and his associate, Dr. Voorhees. With the aid of films he demonstrated some

of the vascular surgery which they are undertaking.

Dr. F. Paret moved that we, the County Medical Society, endorse the A.M.A. program for Salk vaccine inoculations for all citizens under the age of 40. It was moved that we, the Middlesex County Medical Society, recommend all who desire vaccination with anti-poliomyelitis vaccine receive it whether through clinics or their private physicians. After discussion, this was passed without dissent.

Dr. A. Fishkoff presented a resolution for the Medical-Surgical Committee which related to the payment of fees when the patient is covered by multiple health insurance plans and/or liability. This was approved and he was instructed to forward this resolution to The Medical Society of New Jersey.

MORTON M. KLEIN, M.D.

Reporter

Monmouth

Under the chairmanship of Dr. John Hardy, its president, the *Monmouth County Medical Society* held its regular meeting on January 23 at Fitkin Memorial Hospital.

The nominating committee presented the following for consideration at the February elections: President, Theodore Schlossbach; President-Elect, David W. McCreight; Secretary-Treasurer, Morton F. Trippe; Assistant Secretary-Treasurer, William J. D'Elia; Reporter, Donald W. Bowne.

Elected to active membership was Dr. Leonard Genova of Red Bank. Associate membership was granted to Drs. Marilyn L. Cannon, Ocean Grove; Raymond E. Conover, Belmar, and George T. Whittle, Asbury Park.

The membership viewed the film, "The Case of the Doubting Doctor" which was furnished through the courtesy of the State Society. A discussion by the membership at large then followed on the present status of the Salk vaccine program and on the duties of the school physician.

The Annual Winter Dinner Dance, under the joint sponsorship of the County Society and its Woman's Auxiliary, was held at the Berkeley-Carteret on January 26. The committee in charge of this most successful affair was headed by Dr. and Mrs. Robert B. Robertson and saw a record of 234 in attendance.

Dr. Willem J. Kolff was guest speaker at the regular meeting of the *Monmouth County Medical Society* on February 27, at Monmouth Memorial Hospital. Dr. Kolff, of the Research Staff of Cleveland Clinic, discussed treatment of renal failure with special reference to the artificial kidney. The program was sponsored by the Monmouth County Heart Association.

The business meeting was under the direction of the president, Dr. John Hardy. The annual election of officers for 1957-58 was held with the following elected: Theodore Schlossbach, president; David W. McCreight, president-elect; Morton F. Trippe, secretary-treasurer; William J. D'Elia, assistant secretary-treasurer; and Donald W. Bowne, reporter. Drs. Peter J. Guthorn, Harold Gabel and Edward J. Salmeri were elected members of the executive committee. Delegates to the State Society were: Drs. Louis F. Albright, C. Byron Blaisdell, John C. Clark, David W. McCreight, and Herman O. Wiley. Alternate Delegates are: Drs. Irving Baer, Mildred Luca, Robert S. McTague, Martin R. Rush, and Frederick C. Steller. Dr. Howard C. Pieper was elected to the judicial committee for a five-year term. Dr. Daniel F. Featherston was named nominating delegate with Dr. Louis F. Albright as alternate nominating delegate.

A report of the public relations committee was given of its press campaign urging all children and adults up to the age of 50 years to receive poliomyelitis immunizations now.

The following two resolutions urging consideration by the House of Delegates at the coming State Convention were passed: 1. That The Medical Society of New Jersey take immediate and definite steps to have medical services of x-ray and pathology deleted from New Jersey Hospital Plan and incorporated in Medical-Surgical Plan for both office and hospital procedures by May 1958. 2. That The Medical Society of New Jersey take immediate and definite steps to prohibit the corporate practice of medicine in New Jersey by May 1958.

The following were elected to full membership: Drs. Walter F. Judge, Spring Lake and Koon T. Ma, Red Bank. Drs. Joseph E. Campbell, Elberon and William J. Pflum, Asbury Park were accepted for associate membership.

DONALD W. BOWNE, M.D.

Reporter

Morris

The guest speaker at the *Morris County Medical Society* meeting on Thursday evening, February 21, 1957, was Dr. Ralph A. Deterling, Associate professor of experimental surgery at College of Physicians and Surgeons. Dr. Deterling addressed the society on open heart surgery. He detailed the history of this field and summarized recent advances. He discussed heart-lung machines and expressed his views about the technical advances necessary before open heart surgery became a more fruitful procedure.

Dr. George Nicoll of Dover presided and a regular business meeting followed the lecture. The Warner Chilcott Company, as usual, were hosts and served refreshments.

ALBERT ABRAHAM, M.D.

Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held on February 19, at the Medical Society Building. Dr. Abraham Shulman, the President, presided.

The following physicians were elected to membership: Active Members—Dr. Edward A. Sciano of East Paterson, Dr. John A. Bollinger of Paterson, Dr. Salvatore J. Giannini of Passaic and Dr. Theodore L. Zahne of Clifton; Associate Members —Dr. Umberto Giannini of Passaic and Dr. Marvin S. Weinreb of Paterson.

Administrative Directive No. 4 from New Jersey Department of Labor and Industry, Division of Workmen's Compensation, in connection with Disputed Medical Bills, was read. Several questions on this subject were raised.

Dr. Shulman spoke about the poliomyelitis eradication program conducted by the New York County Medical Society and asked for the opinion of the members for promoting a similar program in this county. A motion was passed to the effect that we institute a campaign for a poliomyelitis vaccination program, charging $3.00 per injection.

Dr. Shulman reported on the recent Press Dinner Meeting which he felt proved beneficial to both the Society and the Press, in understanding the problems of each. Dr. Yachnin submitted to the membership a suggested procedure whereby a format for our members and the newspapers would be followed in certain newspaper announcements. This was accepted by the members, to be further considered by the Welfare Council as to the proper way of setting it up.

The President then turned the meeting over to Dr. Elias D. Lawrence who introduced the speaker, Robert Turell, M.D., Associate Surgeon in charge of Proctology, Mount Sinai Hospital, N. Y. Dr. Turell's topic was "Adenomas and Hemorrhoids — Problems of Rectal Bleeding." A question period followed.

A collation was served by the Woman's Auxiliary.

DAVID B. LEVINE, M.D.

Reporter

Salem

At the regular monthly meeting of the *Salem County Medical Society* held February 15, 1957, at the DuPont-Penns Grove Country Club, Dr. Harry F. Suter of the Public Relations Committee and Dr. John S. Madara of the State Welfare Committee reported on plans for honoring local doctors who have completed fifty years of medical practice. Dr. Harry W. Fullerton, Jr. reported on a meeting of his Poliomyelitis Vaccination Committee with the Executive Committee at which a press release was prepared stating that the members of the society would cooperate with Salk vaccination clinics now being scheduled in the county this Spring, but recommending that after June 30 Salk vaccine administration be confined to private practitioners' offices and established child health and baby keep-well stations now in operation. The society continues to urge that everyone in the county should receive three inoculations of the Salk vaccine.

Dr. W. Garrett Hume introduced the speaker, Dr. Vincent Mahoney, Professor of Psychiatry at Jefferson Hospital. Dr. Mahoney discussed psychiatry in general practice, with special emphasis on the screening of office patients to select those needing hospitalization or specialist care. For the remaining group who could be handled satisfactorily by the average practitioner in his office, Dr. Mahoney outlined the general principles of successful management. In answer to several questions from the physicians present, he discussed the use of some of the newer tranquilizing and stimulating agents.

A trip through the medical building and a series of short talks on industrial medical problems was the feature of the regular monthly meeting of the *Salem County Medical Society* held on March 15, at the Chambers Works of E. I. Du Pont de Nemours and Company. The Medical Division staff provided society members with guidance through the medical facilities, a brochure describing the operations carried out at this installation, and an excellent dinner at the plant cafeteria.

At a short program before the dinner, various phases of the medical responsibilities involved in the operation of the Chambers Works were outlined by E. E. Evans, M.D., Director of the Medical Division; John W. Wetherhold, M.D. and W. Garrett Hume, M.D., of the medical staff, and Dr. Adrian Lynch of the Industrial Hygiene department. Dr. Isadore Lipkin then presided over the business portion of the meeting, which consisted of the presentation of the report of the Nominating Committee headed by Dr. C. B. Norton. The slate Dr. Norton presented was unopposed by any other nominations and will be voted upon at the April meeting. Dr. Hume is nominated for president, Dr. Charles Gilpatrick for vice-president, Dr. Ford C. Spangler for treasurer, Dr. George Nitshe for secretary, and Dr. W. L. Sprout for recorder. Councillor members of the executive committee will be Past Presidents Norton, Lipkin, and Eugene T. Pashuck. Delegates to The Medical Society of New Jersey are Drs. C. Spencer Davison, Harry W. Fullerton, Jr., and R. Louis Silverman.

W. L. SPROUT, M.D.

Reporter

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

The Truth About Cancer. By C. S. Cameron, M.D. Pp. 268. Englewood Cliffs, N. J., Prentice-Hall, 1956. ($4.95)

Dr. Cameron tells the truth with frankness, objectivity, and forthrightness. Written for the layman, this text embodies an approach that may be helpful to physicians.

This volume surveys the subject and headlines the most significant aspects of present day scientific thinking. It discusses what cancers are, what we know of their predisposing causes, how cancers grow, how they spread, and why they cause death. Types of therapy are reviewed and approximations of present day cure rates are given.

Besides the overall view of malignant disease, Dr. Cameron presents detailed descriptions of common tumors; their natural history, signs, and symptoms. Illustrative case histories are included. The author stresses the importance of early diagnosis, the need for a high index of patient and physician suspicion, and the desirability of comprehensive annual physical examinations for all adults.

This is a readable, realistic, authoritative explanation of the cancer problem. I heartily concur with the publisher that this book has within its covers information which could save lives. The obligation to disseminate this information falls on us all.

WADE N. MILLER, M.D.

Clinical Chemistry; Principles and Procedures. By J. S. Annino. Pp. 280. Boston, Little, Brown, 1956. ($7.50)

This book opens with a description of an analytic balance and Duboscq visual colorimeter and proceeds to a simplified description of a spectrophotometer. This is followed by a discussion of the principles of quantitative analysis. The book includes a method for estimating sodium and potassium which is an original technic developed by the author. Here the author and this reviewer are in disagreement.

Dr. Annino's statement, "that today there is no instrument suitable for use in the clinical laboratory with which serum calcium determinations may be performed both simply and accurately" is not correct. For the past year, I have been routinely quantitating Na, K, Ca and Mg in mine and serum at our laboratory on the Beckman spectrophotometer.

The author closes his preface with the hope that the "book will be of some assistance to those interested in the advancement and improvement of clinical chemistry." The reader is thus led to expect an introductory presentation of electrophoretic methods for proteins and accepted analytic methods for transaminase, 17 ketosteroids, protein-bound iodine and uropepsin. These are not even mentioned despite their worth as adjuncts to clinical medicine.

With the availability of authoritative and reliable textbooks, and manuals covering all of the ordinary laboratory procedures that a technician and a technologist is expected to perform, the need of this particular book on clinical chemistry is not apparent.

WALTER HORDYNSKY, Ph.D.

Albert Schweitzer. Jean Pierhal. New York, 1957. Philosophical Library. Pp. 160. ($3.00)

Surely the greatest ornament of our profession today is the extraordinary Albert Schweitzer. Musicologist, theologian and physician, he is one of the great men of the 20th century — though he was born in the 19th. Medical school admissions' committees sometimes reject applicants who are more than 24 or 25 years old on the theory that that is too late in life to start medical college. Schweitzer was 30 when he entered medical school. In this slim book, Jean Pierhal tells his story with warmth and affection. No doctor or medical student can read it without feeling proud that he is one of this man's professional brethren.

VICTOR HUBERMAN, M.D.

Pediatric Cardiology. Alexander S. Nadas, M.D. Pp. 547. Philadelphia, Saunders, 1957. ($12.00)

Knowledge in the field of cardiology has so increased that reading a new text gives the sensation of learning a new language. Fifty years ago, only four pages in a pediatric text book were devoted to congenital cardiac disease. Now, Dr. Nadas presents us with over 500 pages of elaborately detailed exposition on pediatric cardiology.

The author had hoped to make this a "do it yourself" cardiology. He insists it is not a reference work, or a treatise of physiology of the heart, but a handbook on clinical recognition and management of heart disease in children. The first part of the book covers history, physical examination and routine tests. It also includes radiology, electrocardiography, phonocardiography, and cardiac catheterization. Part Two, "Acquired Heart Disease," reviews rheumatic fever, endocarditis, arrhythmias, pericardial diseases, and the like. The section on congenital heart disease describes in

detail, with pictures and diagrams, the deformities, defects and circuit anomalies. Part Four discusses anesthesia for children with heart disease.

Of particular interest to the hardworking pediatricians who cannot spend time around cardiac centers is the description of cardiac catheterization and the application of the Fick principle for measuring intra-cardiac pressure and the comparisons of outputs of systemic with pulmonary ventricle thus revealing types of shunts. This method has led to controversy as to who is responsible for operation of a cardiac laboratory; the practitioner who felt superior with his knowledge of P wave and T wave, the surgeon, the physiologist or the pharmacologist. Since the slide rule is important, many physicians have had to re-learn Ohm's Law.

Reading all this gives some insight into what is being done. One must actually work in a cardiac clinic to get facility and experience. The book, however, does bring one up-to-date and give a speaking acquaintance with newest cardiological thinking. It will give the pediatrician more competence in appraising and treating cardiac conditions in children.

RALPH N. SHAPIRO, M.D.

Clinical Use of Radio-Isotopes. W. H. Bierwaltes, M.D., Philip C. Johnson, M.D. and Arthur Solari, M.S. Saunders 1957, Philadelphia. Pp. 456. ($11.50)

This book has been compiled to meet the need for training in this new field of medical practice. The authors have stressed *clinical* aspects of radioactive isotopes. This is an excellent text for the student and a good review and reference source for those who have already had training and experience in this field. Half of the book is devoted to radioactive iodine; the most commonly used isotope. Thyroid physiology and the clinical application of radioactive iodine in thyroid disorders are well covered. Ample illustrations, graphs and tables illustrating technics and results of treatment are helpful.

There are additional chapters on radioactive phosphorus and radioactive gold, as well as the less commonly used isotopes. The rich bibliography will prove useful to those who may wish to refer to the original sources.

A separate section is devoted to biologic effects of radiation, health physics and instrumentation. The initiation, management and economics of operating a radioisotope unit are described in detail. The authors are right in saying that those in charge of such a unit whether internist or radiologist should be interested enough in this work to take time off, to spend the months necessary to receive proper training, and continue to devote energy and time to working out the multiplicity of personnel and technical problems that arise in the administration of such a rapidly changing and growing service.

LOUIS J. LEVINSON, M.D.

Roentgen Signs in Clinical Diagnosis. By I. Meschan, M.D., Pp. 1056. Philadelphia, Saunders, 1956. ($20.00)

A new approach to a subject is an excellent reason for the publication of a new book. This work is characterized by several outstanding features. Thus, the radiologic aspects of each subject are considered in their proper relationship to etiology, pathology, clinical considerations and prognosis. The book is copiously illustrated with excellent diagrams. These are frequently used as substitutes for the radiographic reproductions, which unfortunately, leave much to be desired. Practically all of the tables and charts desirable in radiographic interpretation are present in this book. The material is arranged so that it can be used as an index to differential diagnosis. This produces frequent repetitions but it insures the completeness of the category under consideration.

This arrangement and the large amount of material covered preclude a detailed investigation of any one subject. This is partly overcome by bibliographic references. The book is useful as an introduction to radiology, as a reference, and as an index to radiographic differential diagnosis.

CARYE-BELLE HENLE, M.D.

Proctology. H. E. Bacon, M.D., Stuart T. Ross, M.D. and Porfirio Mayo Recio, M.D. Philadelphia, 1956. Lippincott. Pp. 441. ($10.00)

The small area of the colon, rectum and anal canal, has more mischief-potential to the human being than most other areas of equal size. Yet, the subject is often dismissed in the medical literature, consigned to a casual chapter, or even rejected entirely as if it were distasteful. Here at last is a concise, practical book which covers fissures and fistulae, hemorrhoids and volvulus, polyps and cancers, pruritus and procidentia, diverticulitis and papillitis, and all the other painful, dangerous, or disabling afflictions which center in that area. Several hundred illustrations make the text vivid. Minor practical points like how to drape a patient are included. The authors give you tips on history taking, proctologic nursing, and rectal anesthesia. The role of the newest drugs is discussed honestly and usefully. Basic anatomy and pathology are reviewed but the main emphasis is on practical pointers in proctology. If you ever want to go out and find a workmanlike book on the subject, you can bring home the bacon with this one. While this will never make a television spectacular, it is a highly practical bluebook for the surgeon, the gastro-enterologist and the all around family doctor.

ULYSSES M. FRANK, M.D.

TUBERCULOSIS *Abstracts*

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Vol. XXX May, 1957 No. 5

Antimicrobial Therapy in the Treatment of Primary Tuberculosis Pleurisy with Effusion: its Effect Upon the Incidence of Subsequent Tuberculosis Relapse

By Abraham Falk, M.D., and William W. Stead, M.D., The American Review of Tuberculosis and Pulmonary Diseases, December, 1956.

● A comparison is made of the tuberculous complication and recurrence of pleural effusion following primary tuberculous pleurisy with effusion in patients treated with antimicrobial agents and in those untreated. Chemotherapy has reduced the incidence of tuberculous complications from 19 per cent in the untreated group to four per cent in the treated group.

The necessity for a firm clinical diagnosis, is substantiated by a high rate of subsequent tuberculous relapse in those patients without proved tuberculous bacteriologic etiology.

In 1951 it was recommended, on the basis of the Veterans Administration-Armed Forces Study of the therapy of tuberculosis, that all cases of primary tuberculosis pleurisy with effusion (idiopathic pleurisy with effusion) be treated with antimicrobial therapy, as well as by sanatorium care. Recognizing that pleurisy with effusion represents tuberculosis with a high rate of subsequent relapse, it was believed that every effort should be made to reduce it. The present paper is a report of the results of the cooperative study to January 1, 1956.

In addition to the treated series, it was also possible to obtain information on a series of cases in which antimicrobial therapy had not been used. The series for comparison comprise 382 patients who received various periods of chemotherapy and 209 patients who received no chemotherapy. All patients in both series were hospitalized. However, the treated and untreated series were not concurrent in time, nor was there randomization in selection for chemotherapy against untreated controls.

The criteria established for selection of cases were:

The effusion should be of recent origin, preferably not extending over sixty days. The tuberculin skin reaction should be definitely positive before or during treatment. Tubercle bacilli should, when possible, be demonstrated in the aspirated fluid by culture or guinea pig inoculation, either at the beginning of therapy or subsequent to it.

Prior to treatment, every effort should be made to exclude a nontuberculous etiology of the effusion.

Patients having a demonstrable parenchymal lesion at the onset of the effusion were excluded from the study.

The background factors in both series were remarkably similar. Approximately half of the patients in each series were less than thirty years of age, 95 per cent in each series were males, and approximately two-thirds of each group were white. The two sides of the chest were equally affected in each group. None of the patients in either group had roentgenographic evidence of intrapulmonary lesions at the beginning of hospital treatment.

Antimicrobial therapy was not uniform as to the agents used or the duration of therapy. There were 16 patients who received chemotherapy for less than four months, chiefly streptomycin alone. However, more than half the patients received chemotherapy for six months or more with various combinations of antimicrobial agents.

The total rate of tuberculous complications, excluding recurrent effusion, was 19 per cent in the untreated group and four per cent in the group which received chemotherapy. Pulmonary tuberculosis was the most frequent complication in each group and skeletal tuberculosis was the most frequent extrapulmonary complication.

Two deaths were attributable to a tuberculous relapse, both occurring in the group which did not receive chemotherapy. One death occurred in a patient who developed miliary and meningeal tuberculosis twenty-seven months after the onset of the effusion, and the other followed the diagnosis of far advanced pulmonary tuberculosis in a patient twenty-six months after onset of the effusion.

Recurrent pleural effusion was reported in five of the treated group and in 11 of the untreated series. Of the 16 recurrences there were seven on the same side as the inital effusion, eight on the contralateral side, and one bilateral recurrent.

The incidence of complications related to various background factors suggests an apparently lower incidence of extrapulmonary complications in the untreated group, a higher rate of complications among the non-whites who received chemotherapy, and a lower incidence of recurrent effusions in the treated group. None of these comparisons is statistically significant.

The incidence of complications related to the antimicrobial agents used was highest among those treated with streptomycin alone. Most of these patients received chemotherapy for less than four months. The lowest incidence is among those who were treated with drug combinations employing isoniazid, and there were also no reported extrapulmonary complications in this group.

Effect of Chemotherapeutic Regimens Upon the Incidence of Tuberculous Complications in the Treatment of Pleural Effusion

Regimen	Number Treated	Number of Complications	Per Cent
Streptomycin only	12	3	25.0
Streptomycin-PAS	250	11	4.4
Isoniazid-streptomycin or isoniazid-PAS	120	3	2.5

The average length of hospitalization for treatment of the effusion among those who developed tuberculous complications was five months for those receiving no chemotherapy and six months for those who did. Seventy-five per cent of this group developed tuberculous complications while still in the hospital and on chemotherapy. More than half the complications occurred within the first six months of hospital treatment. The majority of relapse in both series occurred in those cases in which the pleural fluid bacteriologic findings had been negative. This is highly significant and further substantiates the necessity for a firm diagnosis on clinical grounds.

The estimated rate (life table method) for all tuberculous complications at the end of four years of observation was 9 per cent in the treated group compared with 25 per cent in the untreated group. A similar analysis for the complication of pulmonary tuberculosis alone indicated a rate of seven per cent and 21 per cent, respectively. The estimated complication rate for the treated cases did not increase after 30 months but did continue to increase for the untreated cases.

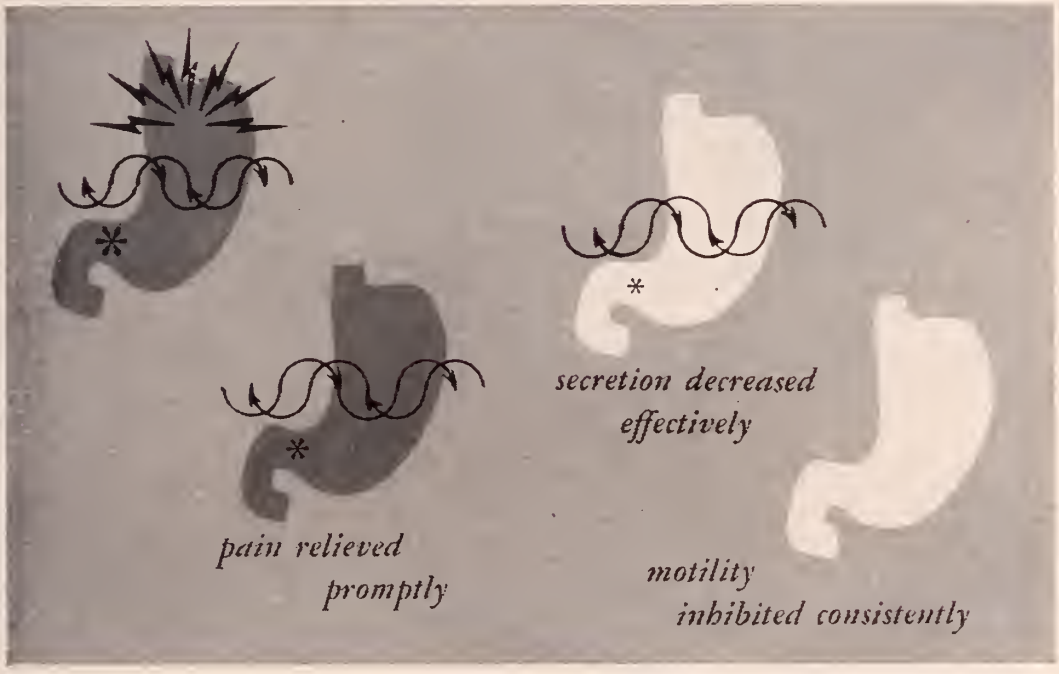
The rate of initial bilateral effusion in both the treated and untreated series was the same. However, the rate of complication was 57 per cent among the patients with bilateral effusion in the untreated series and confirms the clinical impression of the higher morbidity associated with this finding. The rate of complication in the treated group of bilateral effusion was six per cent.

Certain statistical defects exist in these data, primarily in the nonrandomization of cases, the lack of concurrence in time of the two series, the varying regimens of chemotherapy and duration of therapy, and the possibility of incomplete reporting of cases. The relapse rate of series of patients treated prior to the introduction of the antimicrobial drugs is usually estimated at 35 per cent and has varied from 20 to 65 per cent in reports for the five years following onset of the pleural effusion. These data and subsequent reports from the continuing study should offer information of value in estimating the results of chemotherapy in reducing the incidence of tuberculous relapse.

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*Lichstein, J.; Morehouse, M. G., and Osmon, K. L.: Pro-Banthine in the Treatment of Peptic Ulcer. A Clinical Evaluation with Gastric Secretory, Motility and Gastroscopic Studies. Report of 60 cases, Am. J. M. Sc. *232*:156 (Aug.) 1956.

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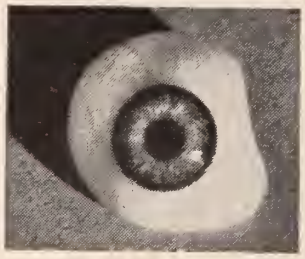
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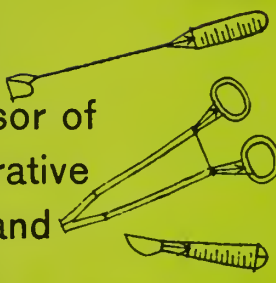
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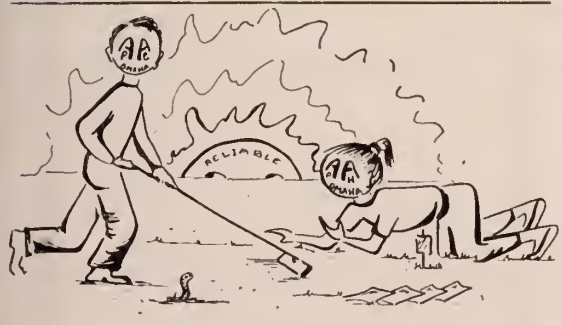
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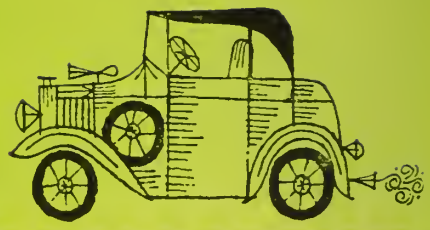
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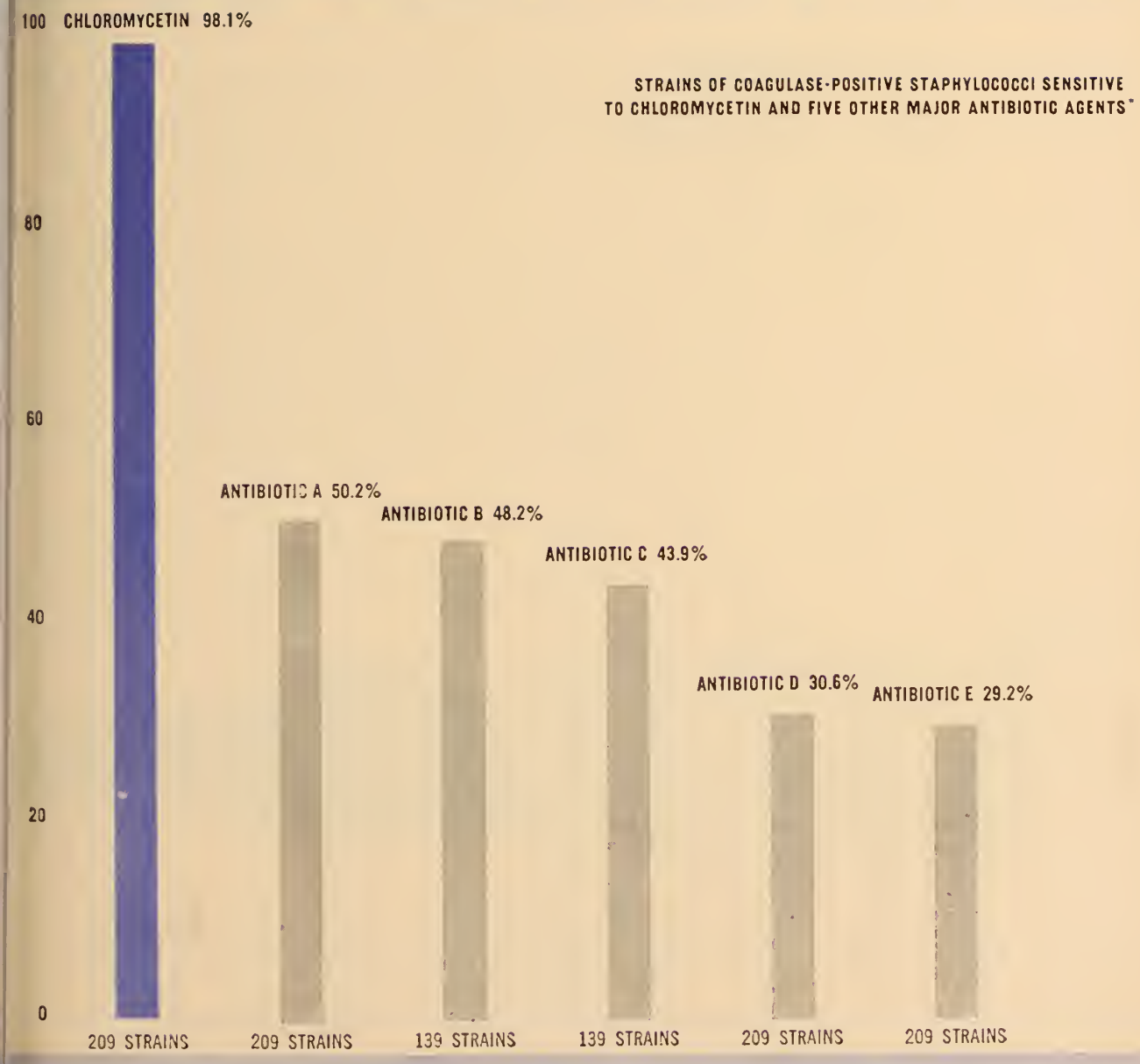
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*Ferguson, J. T., and Linn, F. V. Z.: Antibiotic Med. & Clin. Therapy *3*:329, 1956.

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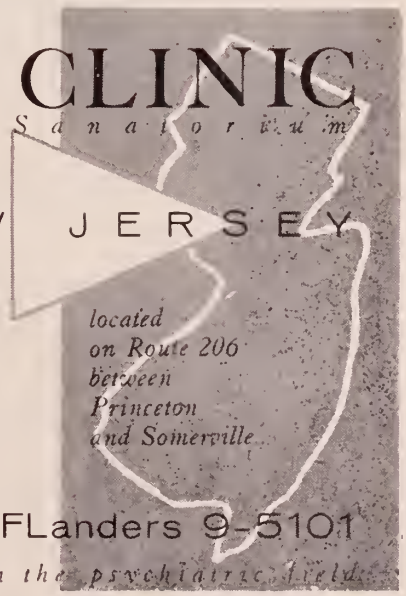
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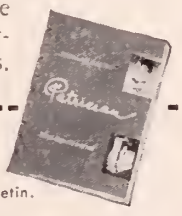
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* This advertisement appears in the June 17th issue of Life: circulation more than 5½ million; total readership, over 15 million.

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serum cholesterol



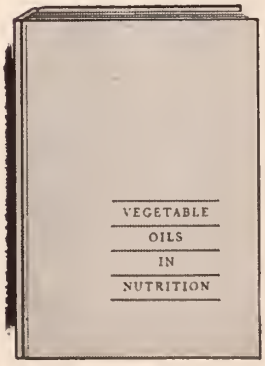
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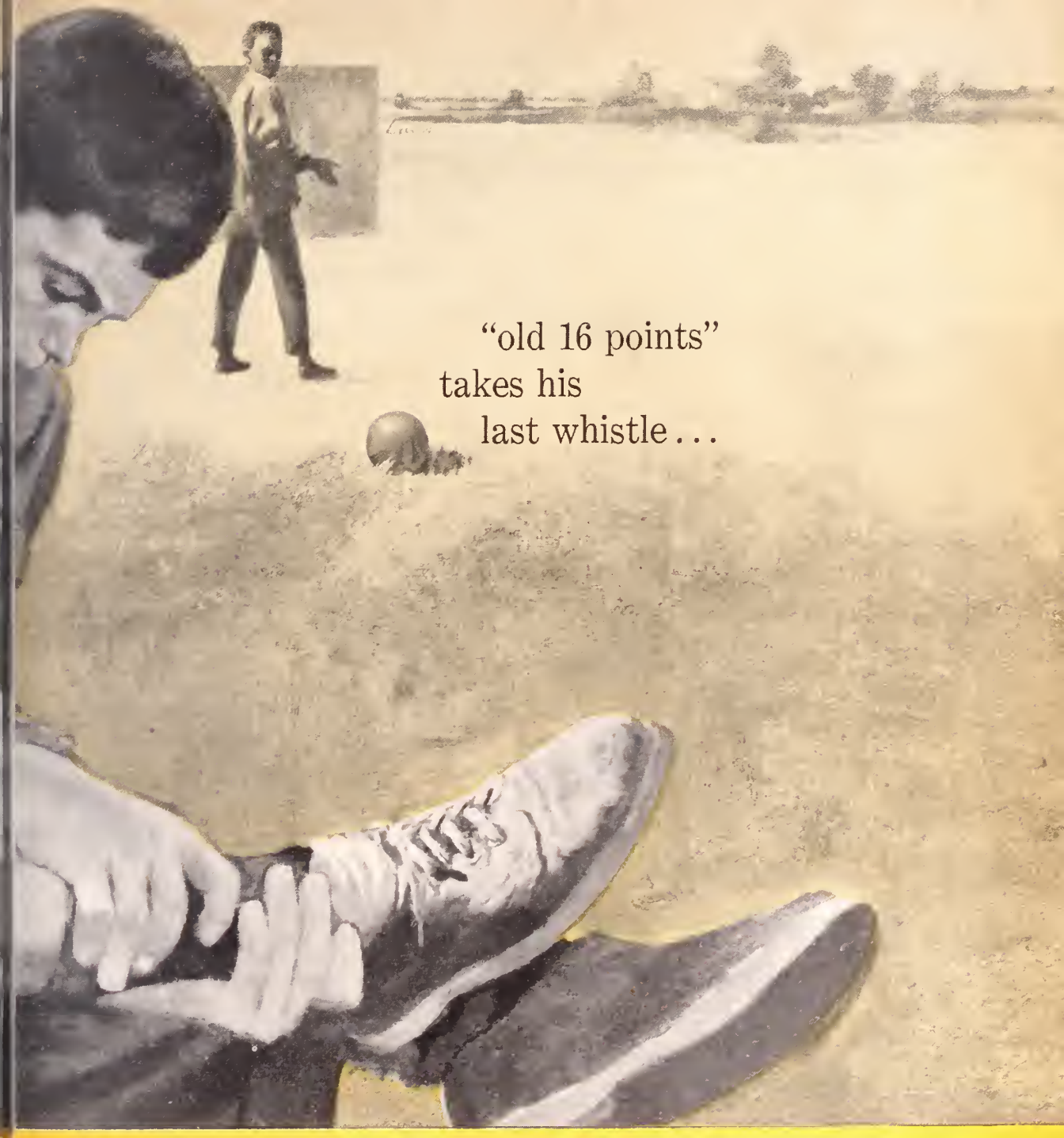
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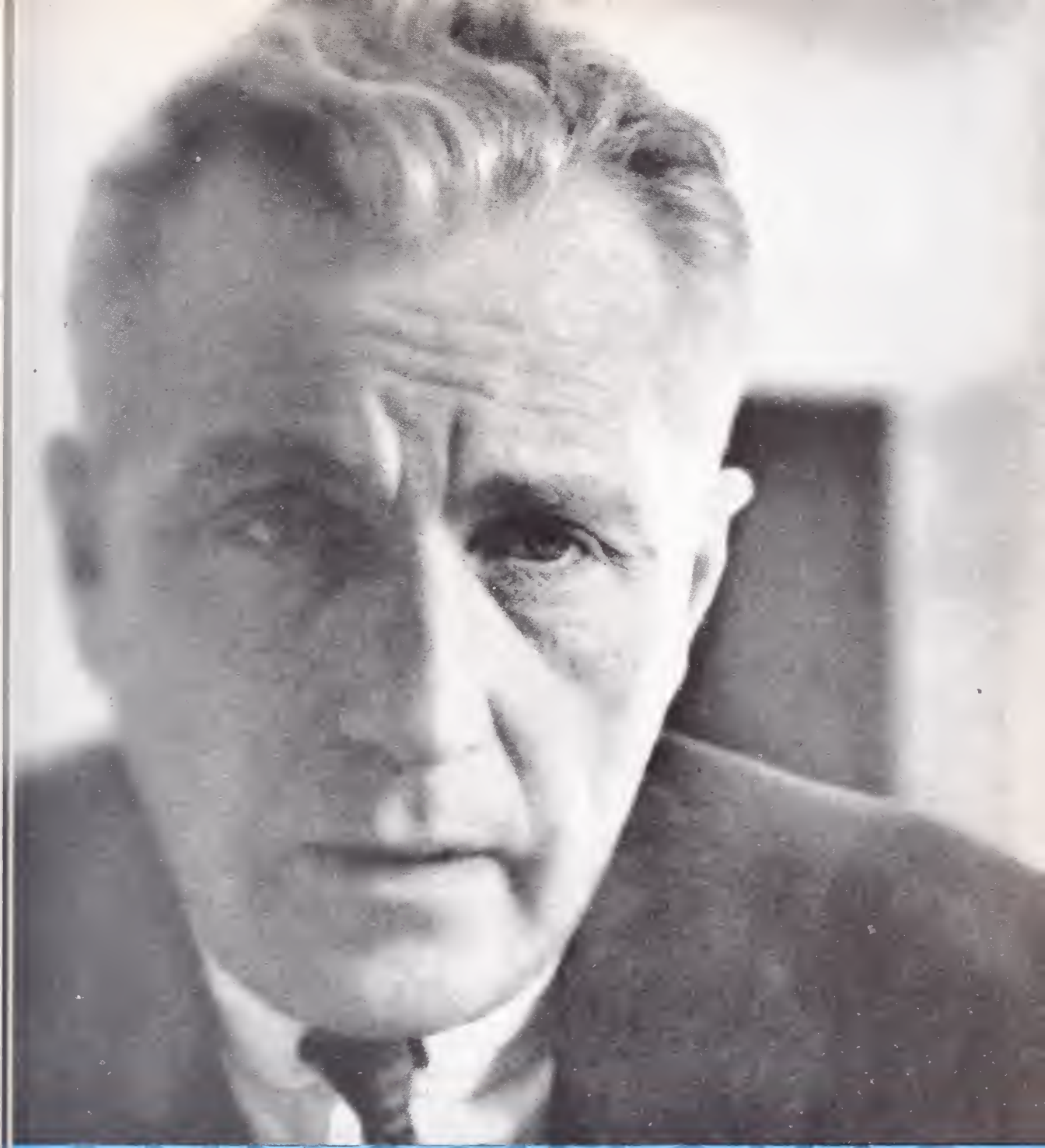
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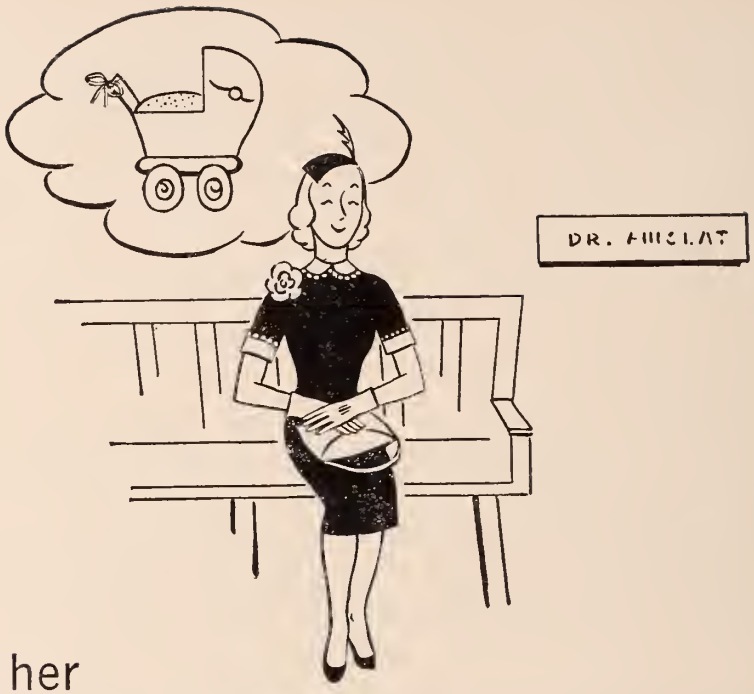
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. . . without nausea

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Cyclizine Hydrochloride and Pyridoxine Hydrochloride

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AMYCIN provides the antimicrobial spectrum of
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even
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fails

in
eczemas
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pruritus (ani et vulvae)
slow healing wounds
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relieves pain and itching, stimulates healing

CLINICALLY EFFECTIVE — Panthoderm Cream quickly and definitely relieved itch, often where "all other measures failed." In various ulcerative and pyogenic skin conditions a "majority healed and many showed various degrees of improvement." Even long standing conditions resistant to other therapy seem to respond to Panthoderm Cream.

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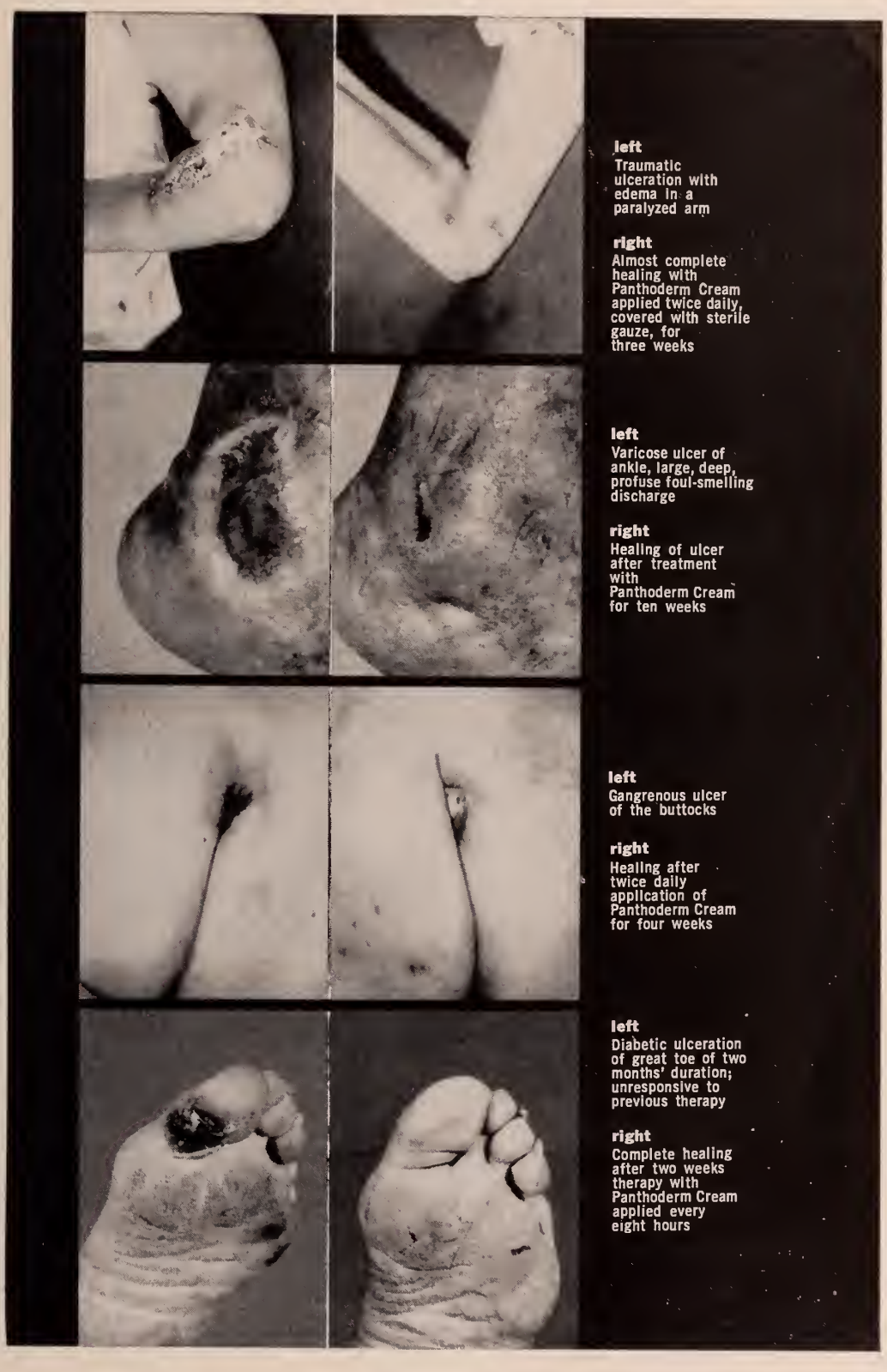


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samples upon request

Recent published reports on Panthoderm Cream.

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2. Schoch, H. G.: The Schoch Letter, May 1952.
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right
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left
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Healing of ulcer after treatment with Panthoderm Cream for ten weeks

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Healing after twice daily application of Panthoderm Cream for four weeks

left
Diabetic ulceration of great toe of two months' duration; unresponsive to previous therapy

right
Complete healing after two weeks therapy with Panthoderm Cream applied every eight hours

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(1) Holt, J. O. S., Jr.: Dallas Med. J. 42:497, 1956. (2) Gelvin, E. P.; McGavack, T. H., and Kenigsberg, S.: Am. J. Digest. Dis. 1:155, 1956. (3) Natenshan, A. L.: Am. Pract. & Digest Treat. 7:1456, 1956.

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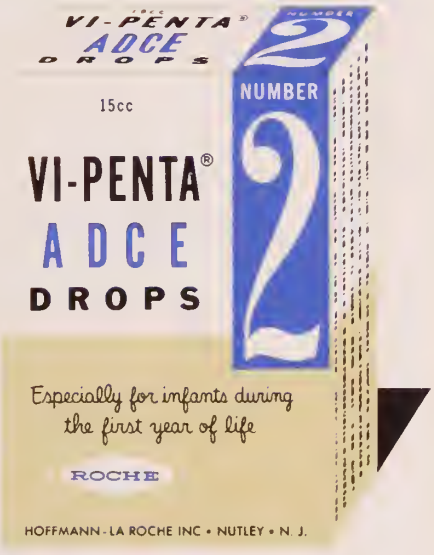
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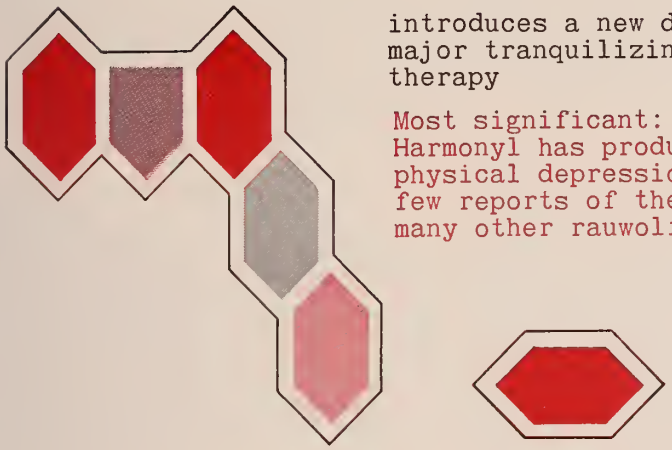
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Safety—plus marked clinical effectiveness

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Of particular interest is the observation that patients became more lucid and alert on Harmonyl therapy. And there was a complete absence of side effects with Harmonyl—although a similar group on reserpine developed such side effects as anorexia, headache, bizarre dreams, shakes, nausea and vomiting.

Following another eight-month study of chronic, hospitalized mental patients, Ferguson[2] stated:

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- Patients experiencing side reactions on reserpine often were completely relieved when changed to Harmonyl.

Ferguson concluded: "*The most notable impressions were the absence of side effects and relatively rapid onset of action with Harmonyl.*"

Comparative studies have shown Harmonyl and reserpine about equal in hypotensive effect. The tranquilizing action of the two drugs also appeared similar—except that few cases of giddiness, vertigo, sense of detached existence or disturbed sleep were seen with Harmonyl.

Professional literature is available upon request. Harmonyl is supplied in 0.1-mg., 0.25-mg., and 1-mg. tablets. Abbott

References: 1. Communication to Abbott Laboratories, 1956. 2. Ferguson, J. T.: Comparison of Reserpine and Harmonyl in Psychiatric Patients: A Preliminary Report, Journal Lancet, 76:389, December, 1956. *Trademark

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1. Wilkins, R. W.: Ann. New York Acad. Sc. 59:36, 1954. 2. Meilman, E.: Circulation 13:596, 1956. 3. Wolferth, C. C.: Pennsylvania M. J. 59:327, 1956.

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1. *Prednisolone buffered*—the newest and most potent of the "predni-steroids" for prompt relief of joint pain and arrest of the destructive inflammatory process.

2. *Meprobamate*—the newest and safest of the muscle-relaxant tranquilizers for profound relaxation of skeletal muscle in spasm.

Tolerance to this combination is good because there is little likelihood of sodium retention, potassium depletion or gastric distress with buffered prednisolone, and meprobamate rarely produces significant side effects in therapeutic dosage.

An additional important therapeutic benefit, often overlooked, stems from the tranquilizing action of meprobamate. This component of MEPROLONE relieves mental tension and anxiety so often manifest in arthritics, making them more amenable to other rehabilitation measures.

INDICATIONS: A wide variety of conditions, in which four symptoms predominate: *a*) inflammation *b*) muscle spasm *c*) anxiety and tension *d*) discomfort and disability; i.e., rheumatoid arthritis, rheumatoid spondylitis (Marie-Strümpell disease), Still's disease, psoriatic arthritis, osteo-

Therapeutic benefits of MEPROLONE compared with traditional

	relieves pain	suppresses inflam-mation	relaxes muscle	eases anxiety
Salicylates	✓	✓		
Muscle relaxants			✓1	
Tranquillizers				✓1
Steroids	✓	✓		
MEPROLONE	✓	✓	✓	✓

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Trichotine douches – incorporating the multiple advantages of sodium lauryl sulfate with the recognized values of other specific or adjunctive agents – may be prescribed as often as required in cases of nonspecific vaginitis and leukorrhea, subacute and chronic cervicitis, senile vaginitis, trichomoniasis, and moniliasis; hot packs are often quickly effective in pruritus vulvae.

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One Vacid insert suppository will hold the pH of the vagina at the normal physiologic level for 24 hours. Symptomatic relief is noted usually the first day and progressive improvement continues until Doderlein bacilli replace the infecting organisms – usually within 7-14 days.

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While discussing purulent cellulitis and sepsis due to staphylococci, Eastman, et al., mentioned erythromycin as a *drug of first choice in treating these conditions.*[2]

Meanwhile, Solomon and Johnston stated, *"in the staphylococcic and streptococcic infections, other than pneumonias, without exception the results of treatment with erythromycin were excellent."*[3]

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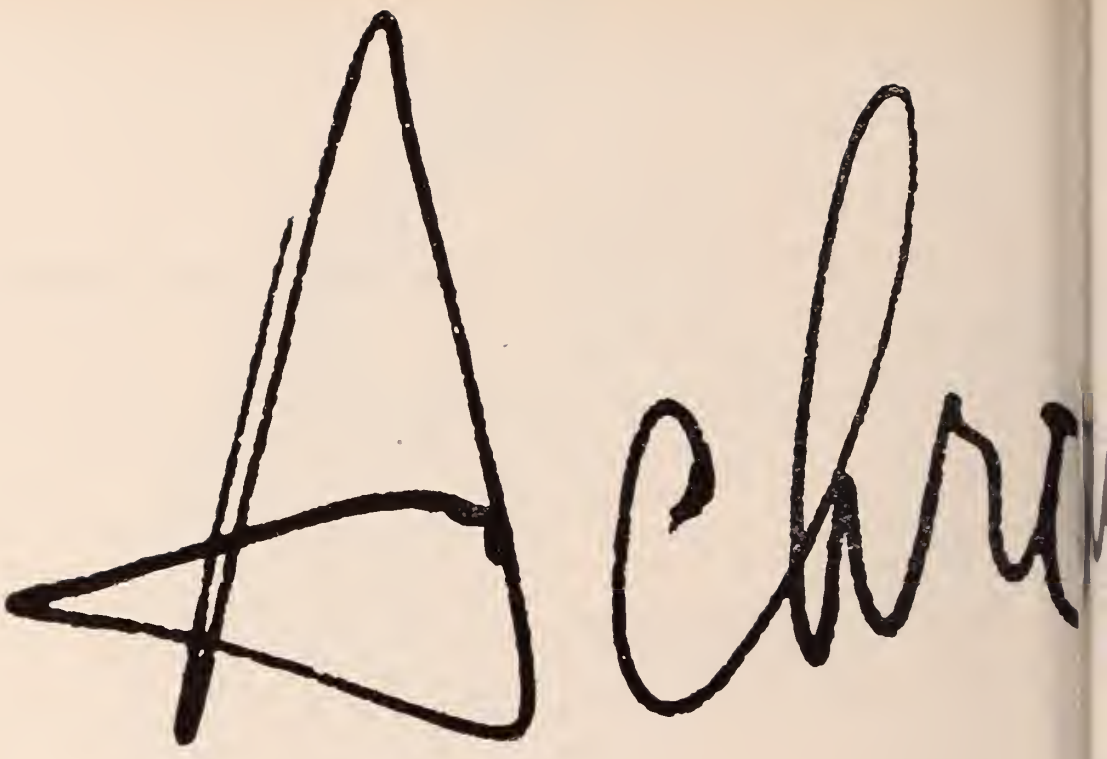
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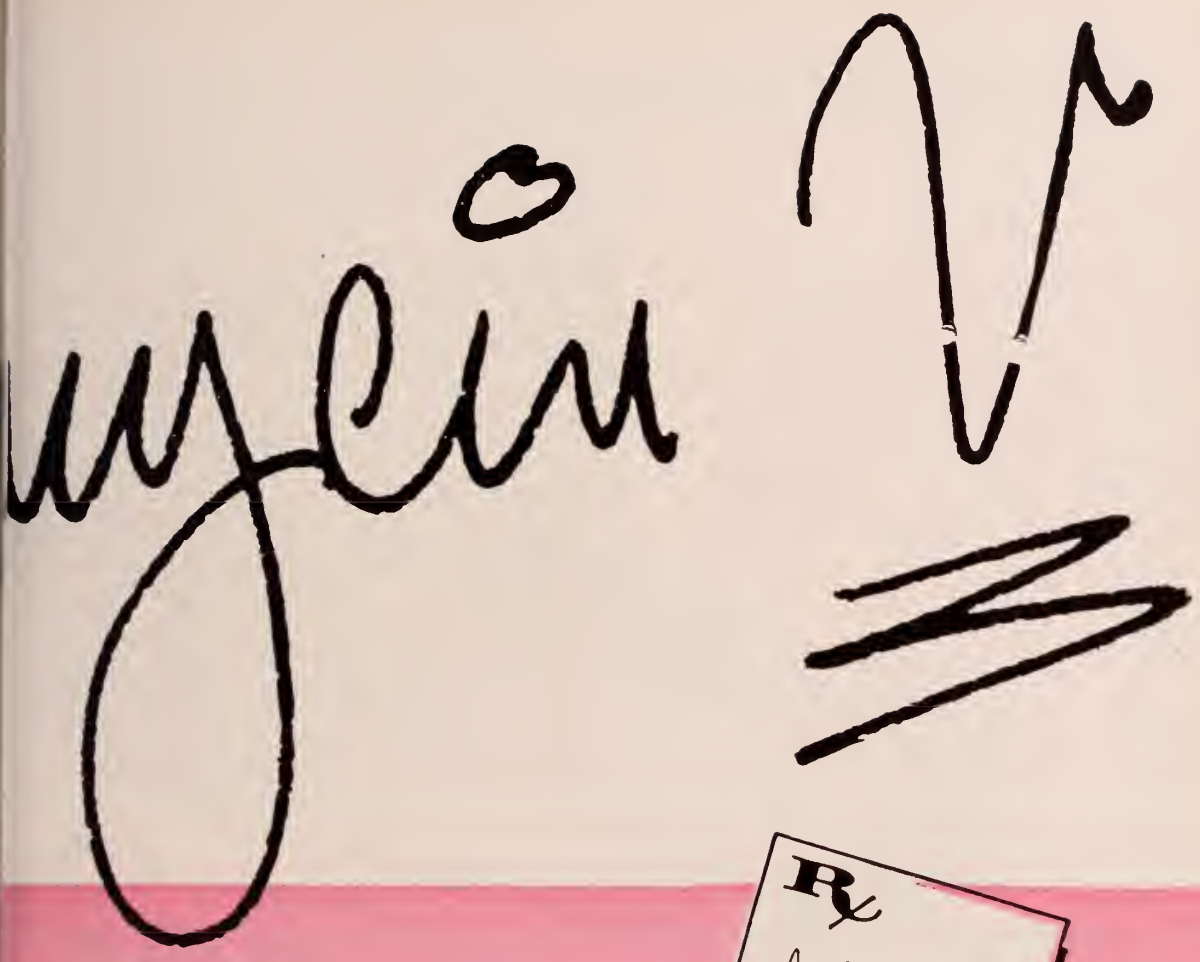
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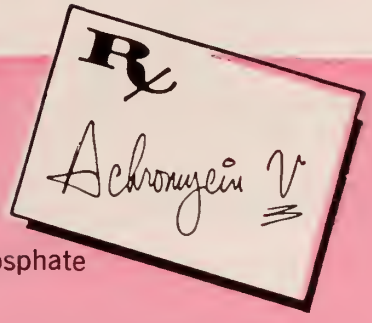
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ACHROMYCIN V dosage: 6-7 mg. per lb. of body weight per day for children and adults.

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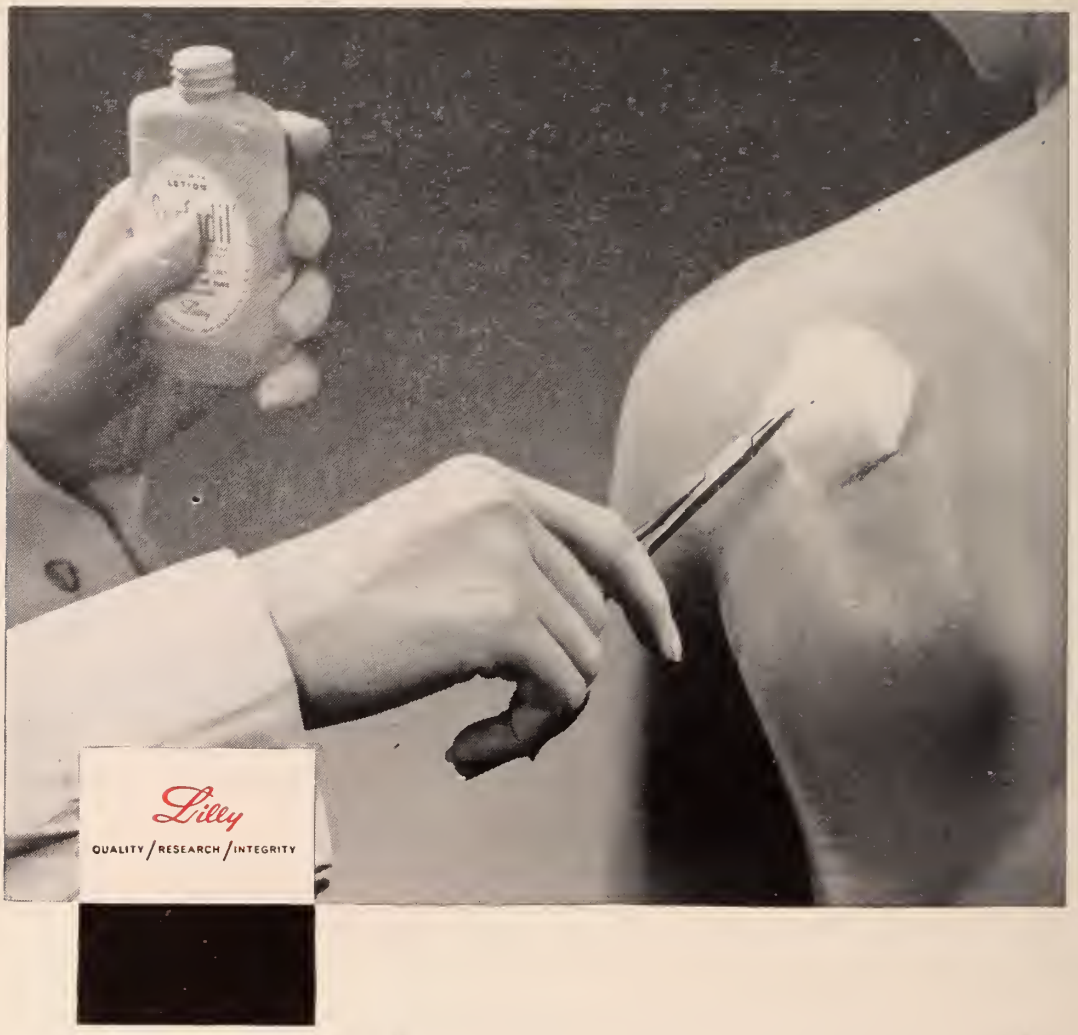
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THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Albert Barker Kump



Some of our finest men—and finest projects—come from the smaller counties. This year, our President is a product of Cumberland County. Born in Bridgeton in 1908 and fortunate in his choice of immediate ancestors, Dr. Kump is the son of Dr. Reba Lloyd and Charles E. Kump.

Dr. Lloyd, a pioneer woman physician of south Jersey, was the first woman to be elected president of a county society in this state. During her professional lifetime, she held the devotion and respect of the people of southern New Jersey. From Charles Kump came to his son stability, unselfish strength, and dedication to all duty, regardless of magnitude.

Dr. Kump went to Blair Academy, then to Johns Hopkins (B.A. 1933) and then to the University of Maryland (M.D. 1938). After interning at Cooper Hospital in Camden, he returned to his native Bridgeton where he entered private practice. He became increasingly interested in surgery, gynecology and obste-

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trics, and in 1946 was named chief of obstetrics at the Bridgeton Hospital. He was active in the Cumberland County Medical Society, holding all the honors that his fellow-physicians in the County could bestow upon him. He became medical director of the Bridgeton plant of Owens-Illinois Glass, and has been active in industrial medicine.

Annually the American Legion in the Cumberland County area selects a project — not an individual—for its "outstanding service to the community" award. Last year, the Legion deviated from tradition and named an individual as well as a project. That individual was Albert Barker Kump, M.D., who was accoladed for having rendered outstanding service to the whole Bridgeton community.

Dr. Kump is married to the former Elizabeth P. Bacon of Bridgeton. They have one son, Albert Lloyd Kump. The Kumps are active in the First Presbyterian Church of Bridgeton.

Dr. Kump is a Fellow of the International College of Surgeons. At the state level, he has worked indefatigably in behalf of organized medicine.

The Dynamics of Life Insurance

More Americans have a stake in life insurance than in any other business. And each year the number sharing the stake grows. In 1956 the nation's families, dealing with 1140 American companies raised their ownership of life insurance to a record level. By the year's end, more than 103,000,000 individual policyholders owned more than 250,000,000 policies. They represent more than $400 billion in protection.

Americans are among the best-insured people in the world. Today more of us own more life insurance and annuities than ever before. But we are putting proportionately less of our income into these policies than did the previous generation. The ratio of premiums to income (after taxes) is less than it was before the depression.

The first function of life insurance is to cushion the economic effects of loss of income following the death of the breadwinner. But other major values are built into a policy, too. Premiums paid for protection over the years, add up to a store of personal savings upon which the policyholder can draw in emergencies. Or he can convert this into retirement income when his family protection needs grow less.

Each premium swells the stream of life insurance savings into a mighty river. A major function of the life companies is to channel these savings into productive investments in business, industry, agriculture and government. These investments earn interest that helps the companies to reduce the cost of insurance. The savings put to work in this fashion accelerate the growth of the entire economy. This means a higher standard of living for everyone.

In inflation, premiums drain off extra consumer purchasing power that might otherwise add more fuel to the fire. In war, the insurance companies marshal their assets in support of extraordinary government expenditures. During World War II, almost half of all life company assets were invested in federal securities. Of interest to us as doctors is the fact the companies cooperate in promoting the health and longevity of the American people. Witness their contribution of almost $9,000,000 to the Life Insurance Medical Research Fund during the last eleven years, to cardiology research alone.

The life companies vie with each other in their search for new business. They also compete for their share of the consumer dollar with all other types of savings opportunities, including banks, savings and loan associations, mutual funds, private pension plans, government bonds and home ownership. Thus, although savings have grown at a more consis-

tent pace in life companies than in any other institution, they account for only about one-tenth of America's total annual savings.

Life insurance is conducted with the shades up all over the house. The watchful eyes of state insurance commissioners are continuously on every major aspect of the business.

Legal supervision as well as managerial choice restricts the companies to certain types of investments. In addition, the position of the companies as trustees for their policyholders makes them seek primarily safety of principal, together with as large and stable investment income as is compatible with safety. Over and above that consideration, the companies' responsibility to the nation as a whole, as a major source of investment capital, makes them weigh carefully the potentialities for general social and economic progress that exist in any given investment opportunity.

Within these limitations, the list of productive investments made by the life companies is an impressive footnote to the unique chronicle of the nation's growth during the past century. Life insurance funds flowed to the sectors of the economy where they were needed most. As the railroad and later the public utility industry became seasoned, substantial amounts of life insurance funds were channeled into those areas. Similarly, life insurance funds are important factors in the development of pipelines, aviation, turnpikes, manufacturing enterprises, urban and rural housing, and small business.

Voluntary, nongovernment health insurance like life insurance is one of the many important reflections of the economic and social development that will distinguish this nation further as it moves forward into the latter half of the twentieth century. But it will also be a reflection with personal meaning to almost every man, woman and child in the land. For broadened health and life insurance programs will contribute largely to a greater individual family security than the country has ever known.

Who Put the Tension in Hypertension?

Why do they say that the good die young? Presumably it is because a good person has a conscience, a bad person doesn't. You cannot have anxiety unless you have a conscience. A good doctor worries about his patients, a good business man worries about the quality of the goods and services he sells, a good friend worries about *your* troubles. So the good worry and develop anxiety.

Fortunately it is not quite like that. The bad person has tension too—not the pricking of conscience but the hungry drives of hatred and hostility. The really malignant emotions are not sympathetic worries, but rather the need to win, the need to dominate, the need to vanquish. These are potentially destructive drives. And here is tension, a destroying, self-eating, corrosive tension. This is a tension that goes readily into hypertension.

But there's more to it than that. Every muscle contraction is a potential contributor to hypertension. To contract a muscle you need glycogen and oxygen. And when the fibre contracts it produces pyruvic acid and creatinine, lactic acid and carbon dioxide. These waste products have to be transported from the muscle for disposal elsewhere.

There is no escape from constant muscle contraction. Life cannot long exist in a state of muscular flabbiness. Perhaps though, we can learn—and then teach—how to relax our musculature between necessary stresses, how to cut down the pressure of competition, and how to provide benign outlets for hostility. To suppress hostility is no help, since the damming back of this will send the blood pressure up. The goal is to feel no hostility. One who can honestly develop an attitude of "I'm not mad at anybody" is a good insurance risk. The final cure will surely come not in medication or surgery but in learning a happier pace of life.

And then the hateful man will die young. The good will survive.

HENRY D. CHIEFFO, M.D.

Union City

Effectiveness of Anticoagulants in Acute Myocardial Infarction*

With a Comparative Analysis of Prognostic Factors

In this workmanlike study, Dr. Chieffo finds that anticoagulants were effective in patients with shock, congestive heart failure, hypertension and thrombo-embolism. A reduction in mortality from 22 to 14 per cent is attributed largely to anticoagulants.

How effective are anticoagulants in acute myocardial infarction? To this highly controversial question, no simple reply can be given. Yet every family doctor, cardiologist and general practitioner must have some swift answer to the question, for a life may depend on it. The query is not only a yes or no matter with respect to the effectiveness of anticoagulants. It is also a problem of determining what complications and incidental conditions are criteria of good response to anticoagulants and which ones are not. We all know that such complications as ventricular fibrillation, other serious arrhythmias, shock, congestive heart failure, thrombo-embolism, bronchopneumonia, and angina pectoris are inclined to influence the prognosis gravely. Previous myocardial infarction and other associated diseases including hypertension, diabetes mellitus, renal and pulmonary disease also seriously affect the course of acute myocardial infarction. Accurate evaluation of anticoagulant therapy in this disease cannot be made without a thorough consideration and analysis of the many prognostic factors involved. Doscher and Poindexter [11] stress the evaluation of these drugs on the basis of the state of the heart at the time of admission. Schnur [13] classifies the patients according to a "pathologic index rating" dependent upon associated pathologic states. He says that the anticoagulants are ineffective in the critically ill patient. Obviously, serious complications such as ventricular fibrillation, cardiac rupture, severe shock and acute myocardial failure will carry a high mortality in spite of anticoagulant therapy.

In view of the controversy now existing on the subject, it seemed timely to see if it were possible to relate the effectiveness of anticoagulants to these various factors. This is the aim of the study here reported.

SCOPE AND METHOD

This study was originally undertaken to determine whether the anticlotting agents should be used routinely in acute infarction of the heart as suggested by Wright.[5,6] All patients admitted to St. Francis Hospital in Jersey City, from January, 1950 to December, 1955 with acute myocardial infarction (con-

*This work is from the cardiology department of the St. Francis Hospital in Jersey City.

Associated Condition	Treated with Anticoagulants			Not Treated with Anticoagulants		
	Cases	Died	Mortality	Cases	Died	Mortality
Previous myocardial infarction	13	2	15%	8	5	62%
Hypertension	27	4	15%	40	12	30%
Shock	6	3	50%	6	5	83%
Congestive heart failure	12	5	41%	11	7	64%
Cerebral hemorrhage or thrombosis	2	0	none	4	3	75%
Thrombo-embolism	4	0	none	2	1	50%
Pulmonary disease	8	1	12%	4	3	75%
Renal disease	2	0	none	7	3	43%
Diabetes mellitus	6	1	17%	5	1	20%
Gross bleeding	3	2	67%	0	0	none

firmed by serial electrocardiograms or necropsy) who survived the initial 24 hours of hospitalization were included in this review. There were 140 cases that met these requirements.

Anticoagulants were administered at the discretion of the attending physicians. They used these drugs most often in the "poor risk" type of patient. A few practitioners, however, did use anticoagulants routinely. There were 63 patients treated with these drugs (henceforth to be referred to as Group A) and 77 patients who did not receive them (Group B). Average duration of hospitalization of the survivors in Group A was 37 days and the average survival period of those in this group who died was 16 days. The survivors of Group B averaged 30 days in the hospital. Those of Group B who expired, lived an average of 11 days. No patient was included who was in the hospital for less than two weeks. Days in excess of six weeks were not included in averaging the total number of days hospitalized. In general, patients in Group B were discharged one week sooner than those in Group A. In the anticoagulant treated group, 67 per cent received Dicumarol® and 27 per cent were given Tromexan®. In most instances the prothrombin time in these cases was maintained at good therapeutic levels.

RESULTS

A CONTROLLED study is almost impossible in this disease because of the many variable factors. Instead, I analyzed each case with respect to these variables to determine if any trend could be observed on the basis of the influence of anticoagulant therapy. Records were studied for such complications as shock, congestive heart failure, thrombo-embolism, and bleeding episodes. Charts were also reviewed in terms of other associated conditions, such as previous myocardial infarction, cerebro-vascular accidents,† pulmonary and renal disease, hypertension, and diabetes mellitus. Other conditions such as arrhythmias and the anginal syndrome could not be adequately analyzed because of incomplete data. The results of this report are summarized in the table.

In Group A (patients treated with anticoagulants) there were 9 deaths out of 63 cases giving a mortality rate of 14 per cent. In Group B (patients *not* treated with anticoagulants) there were 17 deaths out of 77 cases, a death rate of 22 per cent. These results parallel those of Wright, *et al.*[5] who reported a mortality of 16 and 23 per cent for the corresponding groups.

AGE AND SEX

IN GROUP A the survivors' ages ranged from 31 to 70 years with an average age of 56. The deceased ranged from 44 to 77 years with an average age of 57. The survivors in Group B ranged from 35 to 80 years old with an average age of 56. Those who expired ranged from 44 to 80 with an average age of 63. Chi

†It is conceded, of course, that the colloquialism "cerebro-vascular accident" is jargon that is not recognized by the *Standard Nomenclature*. However, it is a convenient term, much simpler than its unwieldy equivalents, and every doctor knows what is meant by the phrase.

square analysis shows no statistically significant difference in the age factor of the survivors in both groups; but there is a meaningful difference in this factor in the deceased group. This suggests that age (probably because of its frequent association with other pathologic states) is a significant factor in mortality here. I do not know why a similar experience was not recorded in patients receiving anticoagulants.

The survivors in Group A included 12 females and 44 males. Those who died included 2 women and 7 men. In Group B, 17 of the 60 survivors were women. In the same group the deceased included 11 females and 6 males. It appears thus that females benefit more from the anticoagulants than do the males. However, because of the small number of women in the series, this conclusion is not statistically valid.

OTHER COMPLICATIONS

Shock. Most patients with acute cardiac infarction sustain some degree of shock which is frequently transitory. The ones included in this category are only those with sustained shock lasting an hour or more. Three of the six patients with this complication died while on anticoagulant therapy, a mortality of 50 per cent. Five out of six *not* on anticoagulants also died, a mortality of 83 per cent.

Congestive Failure. Patients accepted as in this category were those with dyspnea, cyanosis, distended neck veins, basal lung rales, dependent edema and/or enlargement of the liver. Since dyspnea and cyanosis may be transient with the initial shock of the attack, they were not, by themselves, acceptable as indicative of heart failure. They were included here if associated with one of the other physical signs. X-ray evidence of pulmonary congestion was acceptable alone in this category. Five patients from a total of 12 in Group A with this complication died, a death rate of 41 per cent. In Group B, seven out of eleven died; a death rate of 65 per cent.

Thrombo-embolism is not readily amenable to accurate analysis as in many instances it is difficult to prove the existence of an embolic phenomenon or other vascular occlusion. The sudden occlusion of an artery to an extremity can readily be proved to be thrombo-embolic in nature. On the other hand, cerebral infarction and extension of a myocardial infarct is not invariably due to such a phenomenon. Murphy [15] has reported that many infarctions of the brain occur without thrombosis during sleep or hypotensive episodes. The extension of a myocardial infarct is not necessarily due to the extension or propagation of a thrombus in a coronary artery, but can be explained on the basis of coronary insufficiency without occlusion. In fact, infarction of the heart without coronary occlusion [16] has been known for a long time.[18] In pulmonary infarction, the problem of diagnosis is involved and it is hard to distinguish such infarction from bronchopneumonia and congestive failure.[19]

In this study the acceptance of the presence of this complication was based largely upon the opinion and diagnosis of the cardiac consultant. Group A includes 3 cases strongly suspected and one suggestive of pulmonary infarction, and one of sudden hemiplegia. Two of these developed a probable thrombo-embolic episode while receiving adequate doses of an anticoagulant; one sustaining a hemiplegia on the seventh hospital day and the other a probable lung infarct on the 15th day. A third patient developed a pulmonary infarct while on inadequate doses of Dicumarol® and a fourth suffered the pulmonary infarct only after Dicumarol® had been discontinued. Another patient had a lung infarct prior to admission and the use of an anticoagulant. All of these patients survived. In Group B, two cases were highly suggestive of a thrombo-embolic episode; one had an outright hemiplegia and subsequently died. The other had a transient aphasia but survived. A third patient had a probable recurrent coronary occlusion and lived. Thus the mortality in this group was 33 per cent. Apparently the incidence of thrombo-embolism in the latter group is very low: less than 4 per cent. This is in marked contrast to the 41 per cent of Wright [5] but compares favorably with the 10 per cent of

Mintz and Katz.[20] The incidence of this condition in Group A was 6 per cent.

Bleeding Episodes. Only patients with gross bleeding are included here. In Group A there were 3 cases; one with hematuria and two with gastro-intestinal bleeding. The latter two died giving a mortality of 67 per cent. In Group B, no hemorrhagic phenomena were reported.

Previous Myocardial Infarction. Analysis was made of patients with previous attacks of myocardial infarction. In Group A, were 13 with evidence of this condition with 2 deaths, a mortality of 15 per cent. These 13 episodes of multiple myocardial infarction occurred in 11 individuals; 2 of whom had 3 distinct attacks confirmed by serial electrocardiograms; 5 had 2 separate attacks confirmed by serial electrocardiographic changes; 3 had electrocardiographic evidence of combined anterior and posterior wall infarction in a single series of tracings associated with a history of two attacks. Two of these were reported in a previous article.[21] One patient had only a history of a previous episode.

In Group B there were 8 with good evidence of a prior infarction with 5 deaths, a mortality of 62 per cent. The evidences of multiple lesions in the five who died were: one at necropsy showed an old and recent lesion; another had two attacks confirmed by serial electrocardiograms on both occasions; a third had two series of tracings in which the first was strongly suggestive of infarction and the second showed signs of an acute lesion; and 2 cases had signs of multiple infarcts on a single series of electrocardiograms. In the 3 patients who survived one had 3 separate attacks confirmed by serial electrocardiography the second of which was treated without anticoagulants; another had 2 separate distinct infarcts confirmed by serial electrocardiograms; and the third gave only a history of a previous episode.

The lower mortality in Group A (a difference of 47 per cent between the two groups!) strongly suggests a favorable effect of the anticoagulants. On the basis of these figures a previous coronary occlusion would be a definite indication for the use of these agents.

Hypertension. Nearly all patients had evidence of or a history of antecedent hypertension indicated by blood pressures exceeding 150 systolic and 90 diastolic. In Group A were 27 cases, 21 of whom had diastolic pressures of 100 or over, with 4 deaths for a rate of 15 per cent. In Group B were 40 cases, 28 having diastolic pressures of 100 or over, with 12 deaths, an overall mortality of 30 per cent. In terms of the severity of hypertension, the difference in the two groups was minimal. Thus in Group A there were 22 per cent with diastolic pressures of 100 or over while in Group B there were 30 per cent. Again the reduction in mortality noted and attributed to the use of anticoagulants appears to be significant.

Cerebral hemorrhage, thrombosis or embolism. This was manifested by hemiplegia before onset of infarction of the heart. In Group A there were 2 cases with no deaths; and in Group B there were 4 cases with 3 deaths, a mortality of 75 per cent.

Pulmonary Disease. In Group A there were 8 cases with 1 death and a mortality of 12 per cent. In Group B there were 4 cases with 3 deaths, a death rate of 75 per cent.

Renal Disease. In Group A were two patients with evidence of kidney disease and no deaths. In Group B, there were five cases with one death and a mortality of 20 per cent.

Diabetes Mellitus. In Group A were 6 cases with one death, a mortality of 17 per cent. In Group B there were five cases and one death, a 20 per cent mortality. This difference is not statistically significant.

COMMENT

THE expectation that anticoagulants will some day bring about a *marked* reduction in the mortality of acute myocardial infarction appears to be unfounded. This concept is supported by the work of McQuay and his collaborators.[22] In a necropsy study of 133 fatal cases of acute myocardial infarction, they reported that the three major causes of death were myocardial failure, coronary failure, and cardiac rupture in 43, 23 and 15 per cent of the cases respectively. Death due to shock was reported to occur in 9 per cent of the cases.

Only 6 per cent of the deaths were attributed to thrombo-embolism. Coronary failure was defined as "that syndrome of recurrent chest pain after acute infarction without recurrence of infarction." Serious disturbance in cardiac rhythm such as ventricular fibrillation was the precipitating cause of death in these cases. In view of (a) the low mortality due to thrombo-embolism and, (b) the fact that anticlotting agents are not of great value in the three major conditions responsible for deaths in acute myocardial infarction, it appears unlikely that these drugs can reduce the mortality of this disease to any great extent. In the present study, the results indicate an 8 per cent reduction in mortality that could be credited to the use of Dicumarol® and similar agents. This finding is very similar to that cited by Wright *et al.*[5] It seems to corroborate the limited value of anticoagulants.

ALTHOUGH my own figures are far from conclusive, they do reveal a general trend toward the reduction of the death rate that can be attributed to the effect of these drugs in shock, previous myocardial infarction, congestive heart failure, hypertension, thrombo-embolism, and some other conditions associated with an acute infarct of the heart.

Considerable caution is advised in the interpretation of thrombo-embolic complications which are often diagnosed on "presumptive evidence." Arterial thrombosis should not be assumed to be responsible for such clinical states as hemiplegia, extension of a myocardial infarction or gangrene of a limb. Infarction of the brain with hemiplegia[15] has been frequently noted to be non-thrombotic[22] and non-embolic.[23] Cardiac infarction many times is ischemic in nature and its extension may be on the same basis. Recently, a case has been reported[24] of bilateral gangrene of both lower extremities in a patient with myocardial infarction, attributed to arterial insufficiency without occlusion. Thus these conditions often are the result of a severe acute or protracted arterial circulatory insufficiency without occlusion. This state of circulatory impairment may be due to a narrowing of the arterial lumen from atherosclerosis, vasospasm, shock states, myocardial insufficiency or a combination of several of these. It may be the explanation for the alleged thrombo-embolic episodes that occurred in the two patients who received adequate doses of anticoagulants in this series and in those of others. Further, this concept of circulatory insufficiency deserves more widespread recognition as a cause of infarction. Certainly it is supported by pathologic findings that indicate that such a lesion of the brain and heart often occurs without thrombotic occlusion of their corresponding blood supply. A diagnosis of infarction of the lung is hard to come by. Pulmonary infarction has to be differentiated from congestive failure and bronchopneumonia.[18] Cognizance of these problems indicates that infarction in these organs may often be non-thrombo-embolic. Thus conclusions regarding the efficacy of the anticoagulants in purported instances of thrombo-embolism are inaccurate and should be re-evaluated.

TWO deaths were attributed to hemorrhage in the gastro-intestinal tract due to anticoagulant therapy. This highlights the need for caution in administering anticoagulants. Gastro-intestinal lesions such as peptic ulcer, carcinoma, ulcerative lesions and (probably) diverticulitis are highly susceptible to bleeding when anticoagulants are being used. Certain other conditions such as chronic liver disease, renal disease and hemorrhagic disorders should be ruled out before prescribing anticoagulants. To be sure this is sometimes difficult and occasional tragic consequence due to hemorrhage will occur.

The problem of the *routine* use of anticlotting agents in acute myocardial infarction remains unsettled. Many mild cases do well without anticoagulants. Some may have their infarcts on the basis of coronary insufficiency without occlusion. Although unexpected deaths and complications occur in these patients, these are infrequent and do not validate the routine use of these drugs in all instances.

SUMMARY AND CONCLUSIONS

A REVIEW of 140 cases of acute myocardial infarction in a general hospital showed a reduction in mortality from 22 to 14 per cent that could be attributed to the action of anticoagulants. Also noted was a trend toward reduction of mortality in cases with shock, congestive heart failure, previous myocardial infarction, hypertension, thrombo-embolism, diabetes mellitus, and pulmonary and renal disease. In view of these findings, it is concluded that anticoagulants are effective in acute myocardial infarction and should be definitely used in cases with the associated conditions listed above.

The incidence of thrombo-embolic complications in this series was very low: about 5 per cent. It was equally low in patients who received anticoagulants as well as those who did not. The difficulties involved in the diagnosis of this disorder are discussed and to some extent explain the low incidence noted.

There were two deaths due to hemorrhage induced by these drugs and for this reason they must be used with extreme caution. They should not be used when there are contraindications such as peptic ulcer and other ulcerative lesions of the gastro-intestinal tract, liver or renal disease, and hemorrhagic disorders. In view of the dangers involved, *patients admitted with a mild attack who are asymptomatic and suffer from no complications should not be routinely placed on anticoagulants.* The fact that occasional catastrophies will occur in these mild cases does not validate their routine administration. When major bleeding episodes due to the anticoagulants are eliminated then their use in all cases may be justified.

1722 Boulevard

A bibliographic list of 25 citations appears in Dr. Chieffo's reprints.

Sickroom White is Too Sick Looking

Colored linens in hospital rooms for the chronically ill will perk up patients' spirits and minimize the monotonous "sickroom" connotation of hospital white. So says Dr. Samuel M. Reichel, in an article on color therapy in the June 1956 *Hospitals*. Dr. Reichel writes:

"Where a person is continuously confined to a limited area the problem of an artificially-created color environment becomes quite important. Moreover, color studies show that sick persons are more sensitive to environment than are the well."

Dr. Reichel computed the exposed surface area of hospital linens (spreads, sheets, pillow cases and towels) in the average hospital room as 30 square feet. "For emotional, physiologic and esthetic reasons, white is an undesirable color for patients' linens in a chronic disease hospital. Unfortunately, white has become so firmly established as the preferred color for hospital linens that it has become almost ritualistic . . . Psychologically, the excessive use of white emphasizes the abnormal and severe hospital atmosphere, along with its disagreeable and depressing sickroom connotations and previous associations."

"From the physiologic standpoint white may be responsible for the visual fatigue prevalent in chronic disease hospitals. Furthermore, esthetically, pastel colors are attractive. Combinations of pastel colors will reduce the austerity of the hospital atmosphere."

Dr. Reichel advocated not only the substitution of colored linens for white linens, but also color variety to provide "a psychologic change of pace." He suggested that in a chronic disease hospital, warm colors should predominate over cool colors "to aim toward a goal of mild stimulation and to avoid depression."

Theodore R. Robie, M.D.

Montclair

Methitural* in Cerebral Electrotherapy

Most persons can be brought out of a depression through the use of electronic therapy. While this procedure is not without risk, this combination of methitural and succinyl choline will go far towards minimizing the risk.

People of all ages from 10 to 90 may develop melancholia. This may come on suddenly and all too frequently results in suicide or suicidal attempts. There are also a considerable number of people who have been chronically depressed for prolonged periods of months or years. Both the acute and chronic "melancholy illnesses" can be overcome within a period of a few weeks by a course of cerebro-electrotherapy.[1] This specific treatment was discovered within the past twenty years and has gradually lowered the incidence of suicidal deaths.[2] Cerebro-electrotherapy results in the production of controlled generalized convulsive seizures with the hyperkinesis so attenuated by drugs today that no harm can come to the body. The average course runs for about 4 weeks and consists of 12 or more convulsive treatments. A mild amnesia develops during the treatment. The amnesia disappears within one to three weeks after completion of the electrotherapy. Thereafter the patient informs others that he "never felt better in his life." The agonizingly sad expression, the slowed-up activity and the sorrowful tone of voice are replaced by a spontaneously happy expression, normal speed of activity and a gay voice. Most important of all, the urge for suicide is eliminated.

During the past 10 years the pre-treatment apprehensiveness, formerly experienced by patients receiving electro-convulsive therapy, has been minimized or eliminated entirely by intravenous barbiturate anesthesia. Many psychiatrists have used amobarbital (Amytal®) or thiopental (Pentothal®) for this. Some prefer thiamylal (Surital®) or hexobarbital (Evipal®). For some years I have used sodium thiopental in 200 to 400 milligram doses. This reduces the patient's pre-treatment anxiety so that he is willing to come to the office regularly for the treatments. It was exceedingly difficult to get voluntary patients receiving ambulatory therapy to complete a full course of treatment, before we learned how to eliminate the patient's anxiety preceding electro-shock therapy.

In recent years succinyl choline chloride (Anectine®) was introduced as a muscle relaxant during major surgery. Soon thereafter, psychiatrists recognized its potentiality for adequately relaxing the entire skeletal musculature during electro-convulsive therapy. The use of this drug, in proper dosage, now makes it possible to prevent the skeletal fractures which formerly were a major hazard. Unfortunately the powerful muscular force generated by the convulsion[3] sometimes resulted in the fracture of different bones—rarely an arm or leg or, more commonly, one or more

*The methitural used here was in the form of Neraval® (Schering)

vertebrae. The problem had become so serious that one group of psychiatrists[3] reported that when muscle relaxants were *not* used during shock therapy, fractures of the spine occurred in over 20 per cent of all patients treated. This striking datum, demonstrating the excessive frequency of fractures as a complication of electrotherapy, was the major factor in tripling of the cost for psychiatrists' professional liability insurance during recent years. The obvious reason was that the considerable number of fracture complications sometimes resulted in lawsuits. However, the discovery of succinyl's capacity for preventing fractures and for accomplishing this safely, now assures the psychiatrist a sense of security when he administers this electrotherapy to "melancholy" persons. The most important consideration is that this effective therapy can now be made a safe procedure for all patients.

Recently, a new ultra-short-acting barbiturate for intravenous anesthesia was introduced. This is methitural sodium.* I have found it safer, and all treatments are more efficiently completed (*i.e* quicker). Succinyl's paralyzing action endures for only two minutes. It is obvious that an anesthetic that endures for only 4 or 5 minutes would be ideal, and such is the case with methitural.* With both anesthetic and paralyzing drug so quickly eliminated, patients recover quickly from each treatment and may return home within a much shorter period than heretofore.

TECHNIC

THERE are minor differences in the method of administering methitural sodium* (as compared to other barbiturate anesthetics) which must be followed. The latency period lasts from 30 to 50 seconds after intravenous injection before the anesthesia takes effect. Therefore, it is necessary to use the "two-syringe" technic, since the sense of suffocation from the succinyl would be more than the patient could stand unless the anesthetic had taken effect. Thiopental (Pentothal®) anesthesia is immediate, as soon as the effective dose has been administered and therefore both the thiopental and the succinyl can be given in the same syringe. While this easier technic is not possible when methitural* is used, the minor disadvantage of using two syringes is well compensated for by the greater safety assured the patient when this new anesthetic is used.

The patient is placed in bed, with draw sheet under mid-back and shallow pillow (foam rubber) under lumbar region.

A test for estimating proper succinyl dosage must always be carried out before the first treatment. The patient is told that this test injection is necessary and that he may be uncomfortable but that this will pass off quickly. He then is asked to describe his feelings throughout the period. Then 5 milligrams of succinyl choline are quickly injected intravenously. There will be minor, moderate or severe respiratory embarrassment—this is rarely of sufficient degree to require oxygen, but the positive-negative resuscitator is always immediately available on the moveable electrotherapy table. There also will be greater or lesser degree of the following: ptosis, facial flattening, limpness of extremities, inability to lift an extremity, a verbalization of stiffness in back or neck and inability to swallow, sometimes inability to verbalize. The generalized (temporary) prostration is perfectly obvious to the observer. If the prostration is severe about 18 milligrams of succinyl choline are given for the first treatment. The dose would be larger if the patient weighs over 150 pounds and a little less if weight is under 115. If prostration is slight, the dosage of succinyl would be 28 to 32 milligrams, varying with the patient's weight. If prostration is moderate, the first dose would be 24 milligrams of succinyl. One waits 5 minutes after test dose is given for elimination of this small quantity of succinyl choline. This is hydrolyzed in 2 minutes by the blood cholinesterase.

Prepare the two syringes for the treatment injections. The first, a 20 cubic centimeter Luerlock®, will contain about 400 to 450 milligrams of methitural* and 3 cubic centimeters of atropine sulphate solution. The second, (a 5 cubic centimeter Luerlock®) will contain the amount of succinyl choline estimated necessary for this first treatment. At this point have the patient inspire 2 deep breaths. Methitural-atropine solution is then injected intravenously in the following manner: about 5 cubic centimeters of the combined solution first, then pause for perhaps 30 seconds. If patient does not stop talking or go to sleep inject another 1 or 2 cubic centimeters. Then wait again. Usually, at this time, a deep yawn will occur and the patient is soon sleeping soundly. However, a 45 second interval must be allowed before the succinyl injection, to be sure full methitural anesthesia has been induced. The succinyl choline syringe has, in the meantime, been attached to the needle retained in vein, after the first syringe is removed. The total amount of succinyl choline is *quickly* injected, to be sure entire dosage takes

effect at one time. Now there must be a 60 second pause before electrotherapy is administered after succinyl is injected, to be sure full generalized paralysis of muscles has occurred. This can be recognized by lifting the extremity and noting that it is "flail." The assistant has meanwhile placed the electrodes on the temples and made the necessary connections to the Reiter electrostimulator. The nurse removes all dentures. A stop-watch is helpful for accurately timing these delays that are so necessary for good results.

The electro-convulsive treatment is then administered, raising the current intensity control dial (potentiometer) rapidly from 0 to 20 milliamperes and holding it there until the softened convulsion is obviously in progress. When full 4-plus succinylized muscle relaxation has been induced, it is sometimes hard to tell by inspection that convulsion is occurring. Since there is no harm from an extra amount of stimulation with the lesser Reiter Voltages, be sure to maintain position 3 (or 5) intensity for 10 or 15 seconds and the convulsion will certainly occur. Also, by watching the toes carefully, one can see spasm when convulsion is beginning, despite succinyl effect. As soon as the rhythmic generalized muscle twitchings (greatly attenuated by succinyl choline) are evident, the current selector dial (left) is then switched to position one and intensity is lowered to 10 milliamperes and maintained at that level, or slightly lower, until the seizure is over. Then a Guedel airway is quickly inserted by the nurse assistant, followed by a few bursts of minimal electrostimulation on position 1 with about 3 milliamperes, which usually induces the first inspiration. If this does not occur one can begin the oxygen resuscitation,† and inspiration will then recur very soon thereafter. Meanwhile good color is returning to the cyanosed face from the artificially inspired oxygen. In many cases the patient breathes normally within 10 to 30 seconds, if repetitive bursts of electrostimulation alone are given with electrodes moved forward on frontal area just in front of the temporal hairline. This is the method of resuscitation found so successful for reviving persons who have ingested barbiturate overdosage with suicidal intent.

The treating psychiatrist must increase the dosage as indicated after the first treatment, using as a gauge the rating scale of 1+; 2+; 3+; 4+ for description of each electro-convulsive seizure in the record of treatments. Thus whenever the patient returns for subsequent treatment the proper dosage can quickly be calculated on the basis of previous experience with this particular patient.

Another significant finding has come to light since methitural* anesthesia was adopted routinely for all convulsive treatments. For some time past we have been administering monthly maintenance treatments to a few difficult psychiatric patients and in two of these we were accustomed to having them develop severe hyperkinetic and loud verbalizing "furors" following the convulsion. These furors were so severe that leather restraint straps on all extremities were necessary to prevent harm to physician or nurse. Chemical sedation was required to prevent excessive disturbance from the unrestrained and persistent, often vulgar, shouting.

Now that we use methitural,* although we had made the usual preparations for a furor reaction, none have occurred.

We have wondered if the fact that larger doses of succinyl can be safely given under methitural* anesthesia, might be the reason. In any case it is obvious that those who use methitural* are less likely to encounter the unpleasant "furor" reactions which can result in very unpleasant consequences on occasion.

CONCLUSIONS

1. Methitural (Neraval®-Schering), an intravenous barbiturate, has been found to be a more efficient and safer anesthetic for patients undergoing succinyl-relaxed electro-convulsive therapy. When this anesthetic is used, disconcerting "furors" after electro-convulsive therapy are less common.

2. Refinements in technic assure the prevention of the skeletal fractures which were formerly a common complication of electro-convulsive treatment. These refinements emphasize the necessity for having immediately available the positive-negative oxygen resuscitator at all times for patients who do not have spontaneous respiratory response from the temporary apnea following the treatment seizure.

3. It is astounding how often the glum and "melancholy" patient whose repetitive formula is: "I just can't go to work," after less than half the necessary course of E.C.T. has been completed, alters his formula to a hearty "Gee, Doc, I'm anxious to get back to work now!"

4. The need for psychotherapy remains imperative following the course of cerebro-

† I use the E. & J. Oxygen Resuscitator — distributed by: V. E. Ralph & Son. E. Orange, N. J.

electrotherapy. In all "melancholy" persons there are major mental conflicts requiring resolution. Psychotherapy can be advantageously carried out by the psychiatrist who administered the electric treatments, since its successful completion will establish a strong rapport between patient and physician.

I am grateful to the Schering Corporation for furnishing liberal amounts of the methitural under their tradename of Neraval.®

130 Bellevue Avenue

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Cardiac Patients Can Work

Industry should be willing to accept without hesitation the cardiac patient who can do ordinary physical activity without discomfort, Drs. Don W. Chapman and P. T. Lai concluded from a study of 100 coronary patients followed up over a five-year period.*

"We believe that ordinarily a patient with uncomplicated myocardial infarction can return to moderate duty within four months," the authors declared. "A more enlightened attitude on the part of industry, the community, the insurance companies and the patient all combine to add to the basic security of the cardiac patient."

Of the 100 cases studied, 97 per cent returned to full (49 per cent) or part time work. Almost three-quarters of them (74 per cent) were able to return to work in 14 weeks and the majority of the remainder before five months.

In another study 82 patients with myocardial infarctions or angina pectoris were followed in their jobs at a large refinery plant. Of the 50 having had infarctions, 22 returned to their previous jobs with no significant occupational change and 28 returned to limited assignments. "There was no loss in productivity or effectiveness when transferred to other jobs," the physicians stated.

Only two of the 82 employees were found to have an excessive amount of absenteeism due to cardiovascular disease. Only 6 per cent of the whole groups were found to have significant or partially disabling degrees of neurosis.

By the employment of factual analyses of both the physical demands of the job and the physical capacities of the man, the selection of the right job for the handicapped cardiac employee may be accomplished, the study emphasized.

"The dread of termination or premature retirement at a lower rate of pay may in part or whole be eliminated by this evaluation. It works to the mutual advantage of both the company and the employee," the investigators added.

*Chapman, D. W. and Lai, P. T.: Reclamation of the "Coronary Patient" for Work, Southern Medical Journal, 49:685 (July) 1956

E. E. Huber, M.D.

Harvard, Mass.

State and Federal Relationships in Civil Defense Administration

On November 2, 1956, The Medical Society of New Jersey and several affiliated organizations sponsored a blood bank seminar. One of the key speakers was Dr. E. E. Huber who is medical director of our Region of the Federal Civil Defense Administration. This Region includes New Jersey, New York and all of New England.

The organization of the Federal Civil Defense Administration follows the traditional pattern of government in Federal-State relations. Basic authority for operations and control is vested in state and local government. The federal agency serves largely in an advisory and consultative capacity to State Civil Defense Agencies for guidance in planning, training, and assistance in the development of specialized programs and services. The Federal Civil Defense Administration (FCDA), in cooperation with state agencies, has developed a warning system to alert the nation immediately in national emergency, and a series of control centers to insure effective communications. The most important mission of Civil Defense is to make provision for the needs and care of individuals, their welfare, health, medical care and rehabilitation in order to mitigate the effects of major disasters, or attacks. As a national agency, our chief concern is to provide interstate and supplemental assistance to state civil defense agencies in their needs for materials, supplies and personnel, from federal reserves and resources for assistance in state operations. Our national office, at Battle Creek, Michigan, maintains constant contact with the states through seven regional offices. I am the Medical Officer of a region which includes the six New England states plus New York and New Jersey. Our headquarters office and control center are at Harvard, Massachusetts.

The basic relationships of the National Blood Program have changed very little from those prescribed in the directive of the President dated December 10, 1951: The Office of Defense Mobilization is authorized "to provide the authoritative coordination of an integrated and effective program to meet the nation's requirements for blood derivatives and related substances."

A sub committee, representing all the blood program agencies and groups, was developed in the health resources advisory committee of the Office of Defense Mobilization. The policy statement of this committee prescribed that FCDA should coordinate existing blood programs to meet the requirements of national emergencies. In conformity with its traditional responsibilities, the American Red Cross is designated as the blood collection agency for the defense needs of the national program. The Office of Defense Mobilization was directed to give first priority considerations to the needs of the armed services for whole blood transfusion purposes. Second priority considerations are allocations for civilian

needs for whole blood and blood derivatives. That remaining should be allocated first, for immediate needs, and second, to establish adequate national reserves.

Our blood banks are *not* in a state of operational readiness for emergencies. During the last national civil defense exercise, blood program representatives of the American Red Cross worked directly with us at each of our regional offices. In our region, during the mock exercise, it was determined that the residual blood collection capacity of our areas unaffected by the mock attacks, could provide 26,000 pints in an 8 hour period. This could be expanded to 90,000 pints if all residual blood banks operated on a 24-hour basis. Even this was only half enough for the casualty load experienced as a result of the mock attacks. These blood reserves were those released by state and local civil defense agencies for civilian needs. Requests of the Armed Services for blood were not a factor in the exercise.

It is proposed by FCDA that 400,000 pints of blood reserves will be collected for processing into serum albumin. The American Red Cross has asked the National Blood Council to develop plans for such action. The Council includes representatives of the American Medical Association, the American Hospital Association, The American Association of Blood Banks, and the American Society of Clinical Pathologists. Unfortunately, a very large number of the blood banks in the nation (with no specific state programs of certification comparable to that of the National Institutes of Health) cannot be presently considered as resource agencies for collection of these reserves. Measures should be taken to correct these deficiencies to utilize the collection potentials of all blood banks on some basis of uniformity.

I wish to tell you about the FCDA stockpiling program to support the requirements of state civil defense agencies for the emergency resuscitation of casualties. These supplies include blood collection equipment, blood derivatives, and plasma volume expanders such as dextran, polyvinylpyrrolidone (P.V.P.) and intravenous solutions. Our federal procurement program is based on an expected surviving casualty load of 5 million casualties. The potential demand for fresh blood will reach the staggering figure of 3,375,000 pints during the first 72 hours. Each million of casualties surviving 24 hours would require 75,000 pints the first 8 or 10 hours; 600,000 more the next 60 hours, and an additional 825,000 pints for the first 21 days. During the same period, the need for blood derivatives would total 400,000 pints, and 1,100,000 units of plasma volume expanders.

State civil defense agencies are expected to obtain essential medical supplies and equipment to provide medical care for the first 8 to 12 hours after attack until federal reserves can be supplied from our federal warehouses. The state agency of New Jersey was among the first to obtain, package, distribute and store its 285 emergency first aid stations, and blood collection equipment, with the financial assistance of FCDA. Other critical target states within our region have acted promptly, and there are now more than a million sets of blood collection equipment in readiness for use as procured by state and local civil defense jurisdictions.

Collection sets in reserve medical stockpiles are sufficient for about 2½ million emergency transfusions. These supplies would be assembled in functional assortments for ready shipment to blood banks, sufficient for processing 1000 blood donations, in each such assortment or replenishment unit. Discussions are under way for pre-positioning these supplies near blood bank centers for ready availability in emergency.

Since whole blood cannot be stored beyond 2 or 3 weeks, and since the supply of blood in attack areas will be very limited for the first 6 hours, reserves of blood derivatives and plasma volume expanders were also stocked. During the early years of FCDA, considerable dried plasma was stockpiled. Much of this has been converted to serum albumin on recommendation of the National Research Council, and assembled, with related supplies for intravenous administration for resuscitation pur-

poses. Each assembly or replenishment unit will be sufficient for 1440 intravenous administrations. In addition, substantial stocks of nasogastric and enteral feeding equipment and supplies are in procurement. The several members of the New Jersey Blood Committee were first to point out the need for equipment of this type.

THE serum albumin in 25-Gram, 100 cubic centimeter bottles (as approved by the armed services) is the derivative which best meets all the specifications as a plasma volume expander. It can be used as a 25 per cent solution, if desired, or diluted with a crystalloid and used effectively as a 3 to 5 per cent solution. The National Research Council has reaffirmed that dextran for emergency use is the most useful plasma volume expander now available. It is recommended when whole blood, safe plasma, or serum albumin are not available. Allergic reactions are stated to be infrequent and rarely severe. The Council also says that it is safe to administer the usual one liter dose in the treatment of traumatic or hemorrhagic shock. Extensive experience at this level, in persons with a normal hemostatic mechanism, has not resulted in known clinical difficulty due to abnormal bleeding. However, risks above this level have not been fully evaluated.

If a national disaster were to occur now, the urgency of relative need would be such that little thought would be given to the hazard of jaundice from plasma or to that amount of polyvinylpyrrolidone (P.V.P.), which would be deposited in the tissues. However, the Council reaffirms a previous recommendation that the use of P.V.P. should be limited. No one should receive more than one liter of P.V.P. during his lifetime.

OVER the past several years, FCDA has served as a federal natural disaster agency to coordinate the assistance provided to state and local governments. The hurricanes at Flint, Waco, Worcester, and several other situations have demonstrated that blood banks too must prepare for emergency situations. Any medical facility as a hospital, clinic, or blood bank in emergencies can be surprisingly ineffective even though professionally trained personnel are on hand. Crowds of volunteers on the one hand, and the pressure of large numbers of casualties seeking treatment on the other, may confuse both the blood bank and medical care services at the hospital. Emergency collections may overflow storage facilities or the ability of the services to utilize them, resulting in waste. These occurrences point up the need of effective planning for disasters, for standard procedures of operation, tried and tested by repeated training.

FCDA, too, makes provision for a "contributions program" to state and local agencies for assistance in training programs. These include measures for the establishment of blood donor lists, the training of phlebotomists for blood bank operations, and for assistance in obtaining training aids, materials and supplies. These are the features on which in general FCDA can provide some financial assistance.

The program, envisioned by the Blood Bank Commission for the establishment of standards, to provide for uniformity in technics, and for accreditation of the blood banks in New Jersey, under an effective training program, will comprise a vital link in preparing these resources for national defense.

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Herschel S. Murphy, M.D.

Roselle

Oxytocics in the Third Stage of Labor*

By effectively combining the U.S.P. oxytocin injection and methyl ergonovine, Dr. Murphy is able to involute the uterus with minimal blood loss and minimal nursing assistance.

Posterior pituitary gland extracts and ergot preparations have been generally recognized as the principal oxytocics for the management of the third stage of labor. In 1952, I reported[12] on a method by which the third stage of labor could be simplified and blood loss considerably reduced by using a combination of Pitocin® and Methergine® (methylergonovine tartrate).† As far as I know this was the first detailed description of the use in combination of these two oxytocics.

Methergine® (methylergonovine), a semisynthetic ergot alkaloid, was first synthesized from d'lysergic acid by Stoll and Hofmann.[3] It differs from ergonovine through the presence of an aminobutanol group instead of the aminopropanol group. Many clinical reports[5] have demonstrated that Methergine® is both safe and valuable[15] in the management of the third stage of labor. Quantitively, it is long acting and prompt in onset.[4,5,6,7] It is not known to have any deleterious demonstrable side effects and possesses low toxicity. In addition, it does not show any marked systemic action[8] on blood pressure[10] or pulse rate and maintains blood loss at a minimum.[9] In several instances, it was most effective in contracting the uterus promptly in cases of severe hemorrhage.[12]

Pitocin® has the advantage of acting rapidly and of having a strong contractile action. Care must be taken against overdosage, however, because violent uterine contractions, and even uterine rupture, can result. Goodman and Gilman[16] find that Pitocin® has a short duration of action and a slight pressor effect. Methergine® possesses the same strong and rapid acting oxytocic properties as ergonovine, with the added benefits of greatly reduced pressor effects, a longer duration of action, and very good tolerability.[7,10,12,15]

Greenhill[2] reported on the benefits observed following the use of posterior pituitary extract and ergot preparations or ergonovine after the expulsion of the placenta. In 1940, DeLee[1] commenting on the advantages as well as the harmful effects of posterior pituitary extract stated that he was using "ergonovine to back up the action of solution of posterior pituitary."

Sedation of patients in labor: In many instances, I have found it useful to administer secobarbital,§ 100 milligrams to 200 milligrams (1½ to 3 grains) or meperidine,§ 100 milligrams (2 cubic centimeters), or both to quiet and relax the patient during labor; occasionally, both are repeated. I have noted that scopolamine tends to make the patient more difficult to restrain, and it is not used routinely in our deliveries.

Routine deliveries: Shortly before delivery, if time permits, atropine sulfate 1/150 grain (0.4 milligrams) is given by hypodermic routinely. After the baby is born, 1 cubic centi-

*Read, by invitation, to the staff of the Rahway (N.J.) Memorial Hospital, February 11, 1957.

†The USP designation is Oxytocin injection. Pitocin® is the Parke Davis brand. Methergine® is the Sandoz tradename for their brand of methyl ergonovine tartrate.

§The secobarbital was administered under the Lilly tradename of Seconal® and the meperidine in the Winthrop-Stearns brand, tradenamed Demerol® Hydrochloride.

meter (10 units) of Pitocin® intramuscularly, *never intravenously in this concentrated form,* is administered. Within 3 to 5 minutes the placenta is delivered. I do not use a manual removal of the placenta but have adopted a modification of Crede's delivery. Once the placenta has been delivered, Methergine® 1 cubic centimeter (0.2 milligrams) intravenously or intramuscularly is administered. The uterus stays contracted, and there is usually very little bleeding. If excessive bleeding does occur, it usually happens in those cases where the episiotomy is rather extensive.

Cesarean sections: In cesarean sections, Pitocin® intramuscularly is administered after the peritoneum is opened and we are about ready to start the low bladder flap. Methergine® (0.2 milligrams) is given intravenously as soon as the baby is taken from the uterus. I never use morphine pre-operatively before cesarean section because of its possible adverse effects on the child. We all want the baby to breathe promptly and not be sluggish from the effects of narcotics or overuse of sedatives in the mother.

Breech and forceps delivery: In breech and forceps delivery, as well as when twins are delivered, the same amounts of both Pitocin® and Methergine® are used as designated in routine deliveries above.

Twins: With twins Pitocin® is injected intramuscularly as soon as the second twin is delivered. Occasionally, however, if the uterus shows no activity and is atonic, ½ minim to 1 minim of Pitocin® is administered intramuscularly before the birth of the second twin. The usual dose of Methergine® (0.2 milligrams) intravenously is given after placental delivery.

Eclampsia and pre-eclampsia: In eclampsia or pre-eclampsia, Pitocin® is used because it has little or no effect on the blood pressure. It is administered as soon as the baby is delivered and is followed by a cubic centimeter of Methergine® after placental delivery. In vaginal delivery in placenta previa the method is the "routine" one above described.

Postpartum care: In all instances 0.2 milligram oral tablets (1/320 grain) of Methergine® are started on the day of delivery, after the nausea is over, and are given three times a day until 6 tablets have been taken. If the fundus is not firm and the lochia is excessive and foul, an additional 6 doses are prescribed. However, it has been my experience that in most cases only the first 6 doses are necessary. In some cases, drop ether is given at the time of episiotomy or started just before the child is delivered. This does not appear to modify in any way, the effectiveness of Methergine®. The patient usually remains in the hospital 5 days for normal deliveries, and for cesareans 7 days. She is permitted to sit up on the first postpartum day if there are no complications, and to get out of bed on the second postpartum day.

RESULTS

I PREVIOUSLY reported[12] the favorable results obtained in 135 patients who were treated by the method described above. The second series of 120 patients, which I now present for evaluation, showed equally favorable results when treated by this combined use of oxytocics, *i.e.* posterior pituitary and the semi-synthetic oxytocic, Methergine®.

The rationale for the combined use of Pitocin® and Methergine® is that this method can be of great practical assistance in smaller hospitals where the nursing staff is curtailed and where deliveries are often made by the physician with limited help. After the baby is born, Pitocin® serves to contract the uterus which in turn helps to deliver the placenta. Following delivery of the placenta, Methergine® is given; and a second contraction of the uterus occurs, which hastens involution and permanent contraction. The physician is thus given time between the administration of Pitocin® and the delivery of the placenta to take care of the baby (clean throat and nose, tie cord, wipe the baby off and warm it). The nurse is also free to watch the descent of the uterus by keeping her hands on the uterus, through the abdomen, one below and one on top of the fundus. After the delivery of the placenta, the physician has time to repair the episiotomy and see that the mother and baby are in good condition. Another important ad-

Parity	Series I (135 patients)	Series II (120 patients)	Total (255)	Percentages
Paro O, Gravida I	59	41	100	39.2
Para I	50	43	93	36.4
Para II	15	25	40	15.8
Para III	9	7	16	6.3
Para IV	2	2	4	1.5
Para V	0	2	2	.8
Age Group				
18-24	48	22	70	27.5
25-30	52	59	111	43.5
31-35	26	27	53	20.8
36-40	9	10	19	7.4
41 and over	0	2	2	.8
Method of Delivery				
Spontaneous	99	76	175	68.5
Low forceps	20	17	37	14.5
Mid forceps	1	1	2	.8
Breech	6	3	9	3.5
Cesarean*	9	23	32	12.7
Blood Loss				
Slight loss	47	34	81	31.8
Normal	61	46	107	42.0
Slight excess of normal	10	27	37	14.5
Moderate bleeding	15	13	28	10.9
Severe bleeding (due to lacerations)	2	0	2	.8
Additional Injections				
2 injection of Pitocin® required	1	7	8	3.6
2 injections Methergine® required	4	2	6	2.3
Laceration				
None	130	108	238	93.3
1st degree	3	7	10	3.9
2nd degree	2	5	7	2.7

*Number of cesareans listed above includes personal cases of author and those in which he assisted or performed the operation for other physicians.

vantage of this method is that blood loss is at a minimum.

SUMMARY

1. Two groups of patients were evaluated, one including 135 patients, the other 120 patients. Equally favorable results with the semisynthetic oxytocic, Methergine®, were obtained in both series. I have described a method which can be used by the obstetrician when only limited delivery room help is available. Also described is a delivery procedure in which one cubic centimeter of Pitocin® (10 units) is given intramuscularly following the delivery of the child.

2. One cubic centimeter of Methergine® (0.2 milligrams) is administered either intravenously or intramuscularly following the delivery of the placenta. In this way, the physician with curtailed nursing help can completely manage delivery and adequately take care of both the mother and child.

3. Methergine® is an effective, long-lasting, dependable oxytocic which contracts the uterus firmly and keeps it firm. Its pressor effect is markedly low and blood loss is kept at a minimum. In addition, oral Methergine® tablets can be used postpartum without any danger of side effects or toxicity. The 0.2 milligram oral tablet of Methergine® helps increase rate of involution.

320 Chestnut Street

A bibliography of 17 citations appears in Dr. Murphy's reprints.

Albert Ehrlich, M.D.

Charles Modero, M.D.

Hoboken

Erythroblastosis Fetalis Complicated by Anti-O*

When group O bloods are consistently agglutinated, anti-O should be suspected. The blood of all pregnant women should be screened for antibodies and crossmatched prior to delivery. Then the mother's washed or packed erythrocytes can be transfused into the baby if a compatible donor is not available.

Extraordinary difficulty in crossmatching was encountered when a compatible blood was sought for an exchange transfusion in an erythroblastotic newborn. The presence of antibodies of specificity anti-O and cold agglutinins in the mother's blood—A_1rh (cde) caused agglutination on the major side of the crossmatch of all the group O Rh-negative and group A Rh-negative bloods examined.

This was the fourth pregnancy of a 26-year old white Rh-negative female. The first child was normal at birth and is now living and well. At birth, the second baby was erythroblastotic and required an exchange transfusion. The third pregnancy ended in a spontaneous abortion. This present pregnancy terminated with a seven and a half pound girl, born after a nine months' gestation, a normal labor, and an uncomplicated spontaneous delivery. Thirty minutes after birth, small ecchymoses of the skin of the neck, thorax and inguinal region were noted (Fig. 1). There was a subconjunctival hemorrhage of the infant's left eye and a definite, but not marked degree of icterus of the sclera. The liver was greatly enlarged, extending to the right iliac crest. A direct antiglobulin (Coombs) test on blood from the umbilical cord was strongly positive. An immediate exchange transfusion was ordered. Blood for transfusion was crossmatched against the mother's serum. The



Figure 1. Ecchymoses in skin of neck and thorax of erythroblastotic baby.

*This work is from St. Mary's Hospital in Hoboken.

mother's blood was tested against four Rh-negative group O bloods, and three Rh-negative group A bloods. None of the bloods were compatible. Three bottles of group O Rh-negative blood obtained from a neighboring hospital were also found to be incompatible. A sample of the mother's blood was rushed to the Bellevue Medical Center Blood Bank where it was found that the mother's serum agglutinated red cells of a large number of group O Rh-negative donors. Because the general condition of the baby was so poor it was then suggested by Dr. Lester J. Unger, Director of that bank, that the baby be transfused with the mother's washed red blood cells, or the mother's blood from which plasma had been removed.[5] Three hundred cubic centimeters of blood were drawn from the mother into acid citrate dextrose solution. The blood was allowed to stand for two hours to permit settling of the red cells by gravity. Most of the plasma was drawn off by suction and discarded. Shortly before the mother's red cells could be transfused, the baby died, ten hours after birth.

The striking autopsy findings were in the liver and spleen. The liver weighed 256 Grams—over three times normal. The spleen weighed 15 Grams —twice the normal (Fig. 2). There was a moderate increase of amber fluid in the peritoneal cavity and pericardial sac.

Microscopic examination revealed an extraordinary degree of erythropoiesis in the liver. The sinusoids were engorged with erythroblasts and normoblasts. Extramedullary erythropoiesis was found in the small capillaries of the lung.



Figure 2. Enormous liver, enlarged spleen and ecchymoses in skin of left thigh in erythroblastotic baby.

A subsequent detailed study by Dr. Lester J. Unger, of blood obtained from the mother and baby, revealed the following:

The direct antiglobulin test on the bady's red blood cells was strongly positive. The blood was group A_1 MN Rh_1rh (CDe).

The mother's blood was group A_1 MN rh (cde). Her blood was also positive for Cellano, Vel, U., Kidd and P factors and negative for the Henshaw, Duffy, Kell and Le^a factors.

Examination of the mother's serum revealed anti-Rh_0 (D) in the following titers:

	Units
Saline agglutination method	6
Albumin plasma method	128
Ficinated cell method	256
Antiglobulin method	628
Ficinated cell antiglobulin method	562

Her serum also weakly clumped all group A_2 Rh-negative cells and more strongly all group O Rh-negative cells and failed to clump group A_1 Rh-negative cells as well as her own. When her serum was mixed with secretor saliva (inhibition test) it failed to clump group O cells. Her serum, therefore, contained anti-O. This irregular agglutinin was present in a titer of 6 units. In addition to these antibodies, cold antibodies in a low titer were present, as is always the case with serums containing anti-O.

Careful study of the mother's sera showed, in addition to anti-Rh_0 (D), the presence of anti-O and cold auto agglutinins. It was the anti-O agglutinins in the mother's serum that caused the clumping of the group A_2 rh (cde) and group O rh (cde) bloods.

This is an uncommon antibody.[1,2] The antibody was inhibited by the addition of saliva from a secretor. Therefore it is considered a variant anti-O by some workers and known as anti-O(H) by them.[3,4]

Antibody studies of the mother's blood prior to delivery, revealed strong anti-Rh_0 (D). A control of mother's serum against group O Rh-negative (cde) cells was omitted in the antibody study. Consequently, anti-O was not detected. However, *if crossmatching had been attempted with group A_2 Rh-negative or group O Rh-negative blood against the mother's serum, then an incompatibility would have indicated the presence of an additional antibody.*

Crossmatching was attempted only when blood for an exchange transfusion was urgently needed.

It is recommended that blood of all pregnant women be screened for antibodies and a satisfactory crossmatch be completed before parturition. In this way, one can quickly carry out either a transfusion on the mother or a replacement transfusion on the newborn. By means of pre-parturition crossmatch, the terrible pressure of a night *statim* request for blood for an emergency exchange transfusion is eliminated. Incompatibility incurred in a pre-parturition crossmatch, would also warn the physician of the presence of an antibody not discovered in the original antibody study and give the laboratory time to identify this antibody.

CONCLUSIONS

1. The presence of a rare antibody, anti-O, in the serum of an Rh-negative mother together with anti-Rh_0 (D) as well as autoantibodies, resulted in unusual difficulties in finding a compatible donor.

2. The presence of anti-O should be suspected when group O bloods are consistently agglutinated.

3. Blood in all pregnant women should be screened for antibodies and be crossmatched prior to parturition.

4. The mother's packed red cells, or washed red cells, can be transfused into her baby if difficulties in obtaining a compatible donor are encountered.

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New Building at N. J. N-P Institute

The Edward A. Strecker building at the New Jersey Neuro-Psychiatric Institute, Princeton, will be dedicated on June 28, 1957. The building is named after Dr. Edward A. Strecker, emeritus Professor of Psychiatry at the University of Pennsylvania, who has long been an advocate of increased awareness of the needs for preventive psychiatry. Dr. Strecker has been recently appointed as the first Professor of Psychiatry at the Seton Hall College of Medicine and Dentistry, Jersey City.

To the community surrounding the Neuro-Psychiatric Institute, the Strecker Building brings a new vital service in the field of community mental health. One of the divisions within the new unit will provide in-patient service for 15 patients. Emphasis will be on diagnosis and short-term treatment directed at the patient's early return. A smaller section is reserved for those requiring more intensive treatment. In addition, the plans are to provide treatment of 50 patients in the Out-Patient division, its aim being to prevent breakdown requiring long-term custodial care by earlier diagnosis and treatment.

Vincent Scudese, M.D.

Newark

Frank A. Franklin, M.D.

Orange

Hip Disability Associated with Irradiation of a Pelvic Organ

Radiation may cure, but radiation may irritate. In radiating a pelvic organ, there may be damage to the thigh or hip. It is sometimes hard to tell whether the pain is due to an extension of the original malignant process or whether it is a complication of the radiation. Doctors Scudese and Franklin offer a formulation for differential diagnosis.

Hip disability in pelvic malignant organs which have received irradiation has presented an orthopedic problem in terms of diagnosis and treatment. This disability consists of pain of the hip joint associated with spasm, limitation of abduction of the femur and atrophy of gluteal muscles. It can signify either early irradiation osteoporosis, later irradiation fracture of the hip or late rare irradiation non-union of femoral neck with aseptic necrosis of the femoral head. These conditions, however, must be differentiated from another condition such as metastatic involvement from the primary gynecologic lesion and from other minor unrelated conditions such as osteoporosis, osteomalacia, hyperparathyroidism, multiple myeloma, bone sarcoma and osteomyelitis. When the doctor is confronted with a disability of the hip with the history of radiation plus history of carcinoma of a gynecologic organ, he must determine if the disability represents (a) irradiation disease, (b) extension of the carcinoma or (c) some other destructive disease. If there is no exact diagnosis, the patient may be treated for metastasis and receive palliative treatment whereas she should have received specific treatment for irradiation disease of the hip. Thus, instead of being treated for an ordinary fractured hip, with nailing, the patient may unnecessarily progress to a rare non-union of the femoral neck necessitating extensive surgery. It is imperative that some definite signs, symptoms, history, or a combination of these be noticed, to aid in the diagnosis of irradiation disease of the hip. The symptom of pain with its specific history, type and onset can be a definite aid in the diagnosis. The specific type of hip pain in these cases can signify early irradiation osteoporosis, irradiation fracture of the hip, late irradiation non-union of femoral neck or metastatic involvement. The symptom can easily be ignored, treated lightly or noticed late when associated with advanced pathologic bone changes. Metastatic hip pain can be excluded by the presence of areas of destruction intermingled among areas of rarefaction involving the medullary and cortical zones and fracture at the site of non-stress areas. Irradiation hip pain on the other hand will present areas of osteoporosis without de-

struction associated with or without fractures in areas of stress such as the calcar femorale.

Hip pain associated with irradiation of a pelvic malignant gynecologic organ may be acute or chronic. Acute early hip pain comes on gradually and is associated with disability of the hip. This usually develops several months after irradiation. Pain is over the anterior aspect of the hip joint. It may remain localized or radiate downward along the inner aspect of the thigh to the knee. Palpation will reveal severe pain over the front of the hip joint. The hip joint is maintained in adduction and spasm due to severe pain. There will be secondary x-ray skin reaction. Flexion, external rotation and abduction will be limited and painful. Leg measurements along the length of the limb will be normal. Circumference measurements will reveal hypertrophy of the involved thigh. Roentgenograms at this time show punched out areas of rarefaction in the head, femoral neck and upper femoral shaft.

ACUTE *late* hip pain is sudden. It is associated with disability of the hip joint. This pain develops six months to several years following the acute early pain. Kropp noted the association of an acute late hip pain with irradiation. The pain is over the anterior aspect of the hip joint. It then usually radiates downward along the inner aspect of the thigh to the knee. The thigh is maintained in severe painful adduction and spasm. Attempts to abduct the thigh are associated with severe pain. The patient is unable to bear weight on the involved extremity. Examination reveals localized pain over the anterior aspect of the hip joint. Manipulation elicits soft crepitation and abnormal motion in the hip. There is resistance to all ranges of motion. The hip is held in adduction and neutral position as far as rotation is concerned. Leg length measures one-quarter of an inch to one inch of shortening of the femur. There may be a slight bulge over the front of the hip joint with elevation of the greater trochanter upward. Roentgenograms reveal fracture of the femoral neck. Lateral x-rays do not show lateral rotation at the fracture site, such as is often found in a traumatic fracture of the femoral neck. Baensch first reported the development of a spontaneous fracture following irradiation but he did not mention the associated pain factor. Stampfli and Kerr stated that coxa vara may occur at the fracture level due to bending of the bone following irradiation. Smith noted the coxa vara position without the usual external rotation in fracture of the femoral neck complicated by pelvic irradiation.

CHRONIC hip pain is recurring and persistent. This pain is diffuse throughout the hip and may be worse on motion. The pain is both local and radiating. The hip is maintained in adduction and neutral rotation, with limitation of abduction. There is extreme atrophy of the thigh. Motions of the hip joint reveal some crepitation. Leg length measurements reveal one-quarter of an inch to one inch of shortening of the femur. The patient presents a positive Trendelenburg test and walks with a gluteus medius limp. Roentgenograms show a non-union of the femoral neck with absorption at the fracture site and aseptic necrosis of the head.

A well nourished, moderately obese woman age 65 was apparently well until she suddenly noticed vaginal bleeding.

Biopsy revealed a carcinoma of the cervix. At the hospital she received radium therapy (3650 millicurie hours) and was then discharged. A month later she returned for further radium therapy (1440 millicurie hours). She was discharged again to receive office x-ray therapy. From December, 1952 to January, 1953 she received *daily doses* of 222 millicurie hours of radium, to a total of 2200 roentgens to each of four portals. The portals were designed to include the entire pelvis, with both hips receiving lateral portal radiation. At this time, radiation therapy was complicated by irradiation eczema of the vulva and the skin overlying both inguinal regions.

She now began to complain of pain over the left hip. This was experienced over the anterior aspect with radiation along inner aspect of thigh down to the knee. The hip was held in spasm and adduction. Palpation revealed enlarged lymph glands. There was a one-eighth inch swelling of the upper thigh. The patient walked with a glutens medius limp. Trendelenburg was positive on the right side. X-ray examination revealed punched out areas of rarefaction of the neck, trochanter of the left hip. Impression at this time was osteoporosis of the hip due to radiation.

In August 1953 she suddenly developed severe

pain while sleeping and was unable to move the left leg. X-rays on admission to the hospital revealed femoral neck fracture with the head in a varus position, presumably due to radiation. Five months later, she came to the hospital complaining of local and radiating hip pain, limitation of motion and one inch shortening of the femur. X-rays showed femoral neck fracture with non-union and aseptic necrosis of the head. A month later, an arthroplasty of the left hip was done consisting of removal of necrotic head and part of the neck and replacement by means of a Fred Thompson Vitallium hip prosthesis. She was discharged walking with a cane.

Pelvic malignant gynecologic organs as a rule do not commonly metastasize to bones. However, metastasis may occur. When radiation is administered for a pelvic malignant gynecologic organ and pain develops at the hip it is most likely due to irradiation. However, keep in mind the rare possibility of metastasis. This can be ruled out by bone biopsy. It is imperative to watch out for signs of irradiation disease such as bronzing, subcutaneous induration, desquamation of the soft tissues and skin overlying the hip area associated with pain early and later eczema with pain over the hip joint and shortening of the femur. It is necessary to x-ray these hips every four to six weeks to detect x-ray signs of bony rarefaction early and fracture and non-union of hip later. By watching for early and late signs of x-ray dermatitis with hip pain and disability of the hip, you may prevent one of the complications of irradiation such as fracture and non-union. Radiation cases can be classified into three groups: acute insidious hip pain with spasm and limitation of abduction as representing radiation osteoporosis; acute late sudden pain associated with limb shortening of the leg representing radiation femoral neck fractures in varus position; and chronic recurring persistent pain associated with limp and shortening representing radiation femoral neck fracture with absorption and aseptic necrosis of the head.

Recommended treatment for the first group is conservative treatment with bed rest. Avoid weight bearing. Some surgeons do a prophylactic nailing of the hip. The second group of cases should be treated by nailing of the hip. The third group of cases may be treated by removal of the dead head and replacement with a femoral head and neck prosthesis.

SUMMARY

IN IRRADIATION of a pelvic malignant gynecologic organ, the development of pain in the hip associated with disability of the hip is an important diagnostic sign. This sign may develop in acute or chronic form. Acute pain may be early or late. Early acute insidious pain is due to radiation osteoporosis of the hip. Late acute sudden pain is indicative of irradiation femoral neck fracture in varus position. Chronic recurring persistent pain is indicative of non-union with aseptic necrosis of the femoral head. By detecting this important sign of pain as soon as possible, the doctor can institute proper treatment and thereby prevent some of these complications.

464 Mt. Prospect Avenue (Dr. Scudese)

Meniere's Disease*

Meniere's disease is characterized by vertigo, tinnitus, and perceptive deafness. It is subject to spontaneous remissions. Probably, it is the result of vasomotor labyrinthine ischemia. Therapeutic efforts demand a careful history and physical examination to determine the factors—allergic, endocrine, and psychosomatic—which may have etiologic significance.

Surgical destruction of the labyrinth gives relief in cases in which one ear only is affected and should be considered after all medical management has failed.

*Walsh, T. E.: Archives of Otolaryngology, 64:118 (August, 1956)

Isadore Lipkin, M.D.

Penns Grove

Acute Myocardial Infarction at Salem County Memorial Hospital

Our small-town and rural hospitals apparently hesitate to contribute their experiences to the medical literature. Thus, a gold-mine of medical intelligence lies untapped in the record rooms of such hospitals. Here Dr. Lipkin opens the vault in one such hospital and develops some interesting data about myocardial infarction in small-town and rural areas.

A survey was made of the 231 cases of acute myocardial infarction admitted to the Salem County Memorial Hospital between September 1951 and September 1956. This represents 0.9 per cent of all admissions during that period. Eighty-one of the 231 died, making the mortality rate 35 per cent. This rate is comparable to the 34 per cent reported by Russek and Zohman[1] in their 1318 cases admitted to New York hospitals. But this is much higher than the mortality of 21 per cent reported in this Journal by Murray[2] in a series of 211 consecutive private patients treated at Cooper Hospital, Camden.

In our series, 95 cases (41 per cent) were admitted to the hospital within 24 hours of onset. Average hospital stay of all the cases of acute myocardial infarction was 15 days per patient. Average hospital stay of the 81 fatal cases was 5.7 days. Forty-six of the deaths (57 per cent) occurred within the first 24 hours of admission.

Of the 176 male patients, 53 died, a mortality of 30 per cent. This compares to a mortality of 51 per cent in the females — 28 deaths in 55 patients.

TABLE 1.

	Cases	Deaths	Mortality Rate
Male	176	53	30%
Female	55	28	51%

The youngest patient in this series, a 26-year old man, survived. The oldest, a 91-year old man, died. Analysis of incidence and mortality according to age groups reveals the following:

TABLE 2.

Age	Cases	% of Cases	Deaths	Mortality Rate Per Cent
26-30	1	0.4	0	0
31-40	11	4.8	5	46
41-50	37	16.0	5	14
51-60	57	24.7	13	23
61-70	80	34.6	28	35
71-80	30	13.0	20	67
81-90	14	6.1	9	64
91	1	0.4	1	100

In 168 cases, the location of the infarction was shown by the electrocardiogram or autopsy. Ninety-three were anterior with 31 deaths, a mortality rate of 33 per cent. Seventy-five were posterior, with 17 deaths, a mortality rate of 23 per cent.

1. Russek, H. and Zohman, B.: Journal of the American Medical Association, 156:756 (October) 1954

2. Murray, E. N.: Journal of The Medical Society of New Jersey, 53:163 (April) 1956

TABLE 3.

Location	Cases	Deaths	Mortality Rate
Anterior	93	31	33.3%
Posterior	75	17	22.7%

Diabetes mellitus was a significant complication in this series: 36 cases were diabetic. This amounts to 16 per cent of the patients.

Diabetics accounted for 17 deaths: a mortality rate of 47 per cent. In the non-diabetic group of 195 cases, there were 64 deaths, a mortality rate of 33 per cent.

TABLE 4.

	Cases	Deaths	Mortality Rate
Non-diabetic	195	64	32.8%
Diabetic	36	17	47.2%

The poorer prognosis of diabetic cases in this series is even more striking when correlated with the patient's sex. See Table 5.

TABLE 5

	Cases	Deaths	Mortality Rate
Non-diabetic males	157	45	29%
Diabetic males	19	8	42%
Non-diabetic females	38	19	50%
Diabetic females	17	9	53%

Here is our experience with anticoagulant therapy: 103 patients received some such therapy while hospitalized. Their mortality was 26 per cent as compared with a mortality of 42 per cent in the group without anticoagulant therapy. While anticoagulants thus appeared to have some effect on fatality, antibiotics made no difference. This is reflected in Table 6:

TABLE 6

	Cases	Deaths	Mortality Rate
With anticoagulants	103	27	26%
Without anticogulants	128	54	42%
With antibiotics	89	31	35%
Without antibiotics	142	50	35%

SUMMARY

(1) A survey was made of 231 consecutive cases of acute myocardial infarction admitted to the Salem County Memorial Hospital.

(2) Acute myocardial infarction accounted for 0.9 per cent of the total admissions.

(3) The mortality rate was 35.1 per cent. About half of all cases were admitted to the hospital within 24 hours of onset.

(4) Average hospital stay was 15 days per patient.

(5) The following factors were associated with higher mortality rates:

(a) Female sex
(b) Age below 40 and over 60
(c) First 24 hours in the hospital
(d) Diabetes mellitus
(e) Anterior infarction
(f) No anticoagulant therapy

157 West Main Street

A Rubin Test for the Nose?

An automatic device that measures the patency of the nasal respiratory passages and that is useful in gaging improvements resulting from nasal surgery, is now available. Called a "Nasometer" it was developed by Dr. Albert P. Seltzer. The unit is actuated by the patient who exhales through each nasal passage into tubes that operate the "Nasometer." Two pens on a single strip chart respond to this flow of air. If there are no obstructions, the two pens will draw a symmetrical pattern. Obstructions on either side of the nose will cause the pen to produce irregular lines. This points the finger at nasal obstructions without causing any discomfort to the patient.

Further details are obtained from the Royson Engineering Company of Hatboro, Penna.

Carl P. Guzzo, M.D.

Orange

Chronic Relapsing Pancreatitis

This is part of a longer essay on the pancreas which won the 1955 Martland Award of the New Jersey Anatomic and Pathologic Society

Chronic relapsing pancreatitis is a recurrent, progressive disease characterized by repeated attacks of upper abdominal pain with acinar and islet cell dysfunction. This disorder appears to be the result of repeated attacks of acute pancreatitis which in turn may derive from a reflux of bile from a common channel and aggravated by a spasm of the sphincter of Oddi, metaplasia of the ducts or hyperplasia of the ducts. Other factors are acute alcoholism, dietary abuse, trauma, and frequently associated cholelithiasis. It may occur in any age group but is common in the young and middle-aged adult.

The pancreas is enlarged, pale and indurated. The gland becomes swollen, there is an increase in fibrous tissue. Wirsung's duct becomes obstructed. Multilocular cysts form and calculi appear in the ducts and acini. The islets may become more and more destroyed.

Abdominal pain is precipitated by food, referred to the back and flank. Anorexia, nausea, vomiting and loss of weight are other symptoms. Many have diarrhea. Narcotic addiction is frequent. Jaundice may occur from obstruction of the distal common duct or from hepatitis. On physical examination there are minimal findings; occasionally a mass in the epigastrium.

Serum amylase is up early. In advanced cases, the amylase may be low or zero. Diminished secretion is reported with secretin reduction in enzymes and bicarbonate. In a third of the cases, carbohydrate metabolism is altered. Inconstant findings are fat in the stools, and undigested meat fibers. On x-ray, the findings include widening of the duodenal sweep; pancreatic stones may occasionally be seen.

Complications often occur. They are: diabetes mellitus, pancreatic cysts, abscess, fistulae, portal hypertension, or biliary obstruction.

TREATMENT

Bland diet, with no raw fruits or vegetables is prescribed. The treatment program includes methanthelin (Banthine®) and procaine sympathetic block with continuous epidural anesthesia. The surgical approach is sphincterotomy and/or partial pancreatectomy with removal of associated biliary diseases.

Gastrointestinal diversion by gastroenterostomy, pyloric exclusion, gastric resection for relief of duodenal obstruction or associated peptic ulceration are other measures.

Sympathectomy is for those who have persistent pain after sphincterotomy or after partial pancreatectomy. Cysts should certainly be drained or marsupialized. Stones should be removed from the pancreas—singly by lithotomy.

Chronic pancreatitis caused by division or due to traumatic division of the duct of Wirsung at the body of the gland, should be handled by distal pancreatectomy.

Pancreatico-duodenal resection is reserved for patients who have far advanced disease with obstruction of Wirsung's duct; or for those who are not relieved by sphincterotomy. Total pancreatectomy is rarely indicated, but may be required when the pancreas is completely obstructed and atrophic, or when less heroic measures have failed.

A 48-year old man complained of upper abdominal pain for 6 years. The pain was severe, epigastric, with nausea and vomiting. It increased in frequency and severity and x-rays were done. These were negative. Patient was explored, and the gall bladder removed. The signs and symptoms progressed. At the second laparotomy, pancreatic calculi were found, and the common duct was drained. Followup after operation revealed a persistent diarrhea and a 31 pound weight loss. Glucose tolerance test showed a slight diminution in the utilization of glucose. Serum amylase values did not rise following secretin administration. X-ray revealed areas of calcification to the level of the second lumbar and smaller deposits to the midline. There was some distortion of the second part of the duodenum. At operation, numerous adhesions were noted. The head of the pancreas was enlarged and firm. Areas of fat necrosis were scattered diffusely throughout the right upper quadrant. The body and tail of the pancreas were firm and adenomatous. The transverse colon was adherent to the tail of the pancreas. Pancreatico-duodenectomy was done by excising the head and neck of the pancreas. The continuity of the gastrointestinal tract was restored by end to side pancreatico-jejunostomy. Postoperative course was good and the patient was completely relieved of pain and gained weight.

258 Reock Street

Smokers Die Younger

Studies of the smoking habits of patients* with lung cancer and other illnesses conducted among the 40,000 men and women in the British medical profession reveal a significantly higher total mortality among smokers than among nonsmokers. The rate for nonsmokers was 13 per thousand and for heavy smokers 19.

Does giving up smoking diminish the risk of developing lung cancer? For smokers who when the questionnaire was completed, had given up smoking more than 10 years it was 0.59, while for those who were still smoking it was 1.03. The evidence "must be accepted as indicating beyond doubt that *giving up smoking does diminish the liability of smokers to subsequent lung cancer.*"

The analysis concerns male doctors aged 35 and over, among whom there were 1,714 deaths, including 84 from lung cancer. Incidence of death closely correlated with amount smoked.

The highest mortalities occurred among those who reported themselves as continuing to smoke cigarettes on November 1, 1951. Among them the annual death rate rose from 0.95 per 1,000 for smokers of 1 to 14 cigarettes a day, to 1.67 per 1,000 for smokers of 15 to 24 cigarettes a day, and to 2.76 per 1,000 smokers of 25 or more a day — that is, to *forty times the death rate of nonsmokers.*

An analysis of a random sample of the questionnaires shows little difference between the smoking habits of doctors in cities or rural districts. "The contrasts in lung cancer mortality between smokers and nonsmokers and between light, medium, and heavy smokers cannot be attributed to a differential exposure to atmospheric pollution which happens to be associated with smoking habits."

Mortality from coronary thrombosis revealed a significant relationship with smoking. Smoking also may cause breakdown of inactive pulmonary tuberculosis, according to a study of 1,200 patients with respiratory tuberculosis conducted by Dr. Carl C. R. Lowe, University of Birmingham. Among patients with pulmonary tuberculosis over 30 years of age there was a significant deficiency of nonsmokers and light smokers and an excess of moderate and heavy smokers as compared with the controls.

*Doll, Richard: British Medical Journal, 2:1104 (Nov. 10) 1956.

Robert B. Marin, M.D

Montclair

The Island Kingdoms

Two of the common laments are the decline of the general practitioner and the deploring of over-specialization. Dr. Marin focusses on a fresher problem: communication between specialists. Perhaps instead of hearing a requiem, the family doctor will become a communication center among specialists. That's better than being their feeding station.

Webster's dictionary defines an island as a body of land surrounded by water. The analogy between this definition and the present status of medical specialties has evoked much thought among a large segment of the profession and an increasing number of perplexed citizens. The specialist is not new to medicine. There have always been outstanding individuals with unusual perception and ability whose actions and character personify the use of that title. What was rare in the past has now become commonplace.

The early 20's and 30's witnessed a profound and significant change in American medicine with the emergence of numerous specialty groups devoted to the expansion and development of their own field and dedicated to the preservation of the rights of the doctor primarily as a member of a particular group. This creation and growth of professional guilds produced in medicine a situation analogous to the large university with numerous exclusive fraternities. Suddenly, the fraternity, not the university became all important. The change was reflected in an alarming division among individuals and hospital staffs. For a time, an M.D. seemed not enough and the public was quick to sense the change. How healthy this was for medicine, and how helpful for the patient, bears scrutiny. Right now the little man behind the medical eight-ball is both puzzled and perplexed. Should he, in a moment of illness, make his own diagnosis and choose a suitable specialist or should he sit for two hours in the waiting room of that rapidly disappearing specimen, the family doctor, and receive a cursory examination and a few pills. He is told on every side through published media and slogans that only a full examination, preferably on a yearly basis, is adequate. This he cannot receive in ten minutes from the harassed general practitioner, and to cover thoroughly the anatomy would involve at least ten specialists. Hence, the dilemma.

It would be both improper and unfair to blame any special group for this unhappy state. It is increasingly apparent that medicine like industry is passing through a tremendous social and economic transition. In the process, the entire concept of medical care will ultimately change. Most profoundly affected will be the general practitioner, or family doctor. Lest we become nostalgic, let it be clear that the change is merely a change in costume. The obvious process of self-limitation in medicine directly parallels the "specialty era" and is further highlighted by the restrictions imposed by hospital boards, particularly on their

general practice staffs. It is a reasonable expectation that the general practitioner *per se* will gradually give way to the general specialist or personal consultant. By training an internist with an excellent knowledge of psychiatry, the personal specialist will be diagnostician, guide, and medical counselor. The hub of a web covering all branches of medicine and the controlling figure in our personal health problems.

Only by this approach can the confusion, doubt, and apprehension innocently engendered by the specialist age be clarified and medicine as a whole serve, as it was meant to, the best interest of the individual. If the ultimate decision as to ailment is left to the patient, then we are indeed returning to primitive practices, and dynamic action is needed.

For the answer we have only to examine the tremendous contribution made by the American dentist. In two short decades, the patient has been educated to accept and expect the annual and even semi-annual dental "check-up." Here, indeed, the story of preventive dentistry has been told so convincingly that we accept our dental summons as a constructive and necessary health routine. The American pediatrician has found the same approach both proper and intelligent in child care. However, only 25 per cent of all children are under pediatric care. The teeth account anatomically for only one per cent of the complex human. From such facts a profound lesson can be drawn.

1. In spite of tremendous scientific achievements, complex machines and antibiotics, we must still deal primarily with the individual.
2. It is better to prevent than prescribe.
3. Nothing replaces the fundamental conclusions drawn from a complete history and a careful physical examination.
4. The ventilation of feelings and fears are imperative to the patient and profoundly informative to the doctor.
5. There is no logical reason why the health supervision practiced by the pediatrician should not be carried into and throughout our adult life.
6. To terminate both council and care at adolescence is physically, economically, and socially costly.

It is an unpleasant fact that in an era when medical progress and development has been so fruitful, our profession has seen an amply evident loss of public regard for the doctor.

We have, as a group, become apart from our patients; and in the vacuum of poor understanding, patient and profession have equally suffered. Examine well the circumstances influencing this trend. Educational requirements, employment practices, professional standing, and hospital rating have become vital social and personal issues. With typical American enthusiasm, a college education has become the trademark of business success and the three to five year residency a hallmark of the specialist. To produce such high priority, finely-ground businessmen or doctors, academic colleges and medical schools have acquired a degree of personal automation which has had a profound effect on our entire educational structure. We have endorsed scientific brilliance at the cost of humanities, and in doing so have narrowed the spectrum of practical knowledge to an alarming degree.

Gone, for the most part, is that comforting and stabilizing individual, the family doctor. If we are to create and build individual islands of specialization, we must of necessity provide a more adequate system of communication, or central bureau of information. By regrooming the general practitioner to fill this important role, we can provide a necessary and vital service. It is clear how, as in the past, the structure and success of medical care depends primarily upon the preservation of the individual doctor-patient relationship. We may catheterize hearts, replace kidneys, remove lungs, develop super drugs, and do a host of seemingly impossible things. In spite of this, the most important consideration is that the patient primarily seeks understanding and medical security. To that end, both doctor and patient must be educated to their reciprocal needs. A frank talk with the 1957 patient shows a surprisingly perceptive and informed individual. By and large, he knows that a history and physical examination cannot be accomplished in fifteen minutes, and that time is still the most important single contribution the doctor makes to the patient. There is further no question of the willingness of the

patient to pay for good service, and more each day are reaching the conclusion that cheap medicine like any other cheap product is a poor investment.

In a crowded, lusty, high-speed, incredibly mobile world, great changes are forecast for future United States health patterns. Changes that will pose staggering new problems for the entire profession and the individual physician. If medicine looks ahead, and it must, an explosive growth in population is apparent—a five million baby year, an aging population in which half the working force is over forty years old, a marked westward shift in population, and a definite and already begun movement from city to suburb. A rapid expansion in the problems of geriatric and chronic diseases all combines with the world population so increasingly fluid that diseases of every nature may again become a major concern of every American doctor. To meet this future challenge constructively, medicine must completely reappraise its format for merchandising good health. Only by a vigorous drive based on the fundamentals of preventive care can we be effective. With an enlightened and rededicated profession, the entire facilities of modern medicine will be available to the patient on a sound, well supervised basis. The islands may remain intact professionally, but through intelligent communication and proper guidance be readily available to our patients. United in the common purpose of service, our profession will survive all social and economic changes, and with constructive thought and action animate the future of American health.

85 Park Street

Medicine Man Works with Men of Medicine

Indian medicine men are collaborating with the U. S. Public Health Service to promote acceptance of modern medicine among American Indians, Dr. James R. Shaw of the U.S.P.H.S. says in the April 1957 issue of the Journal of the American Hospital Association.

"The medicine man, respected tribal religious leader and practitioner of ancient healing arts, is a welcome collaborator in promoting acceptance of modern medical and hospital care," says Dr. Shaw. Indians have a disease rate higher than that of the general population, widespread poverty, language difficulties, and a lack of understanding of the causes of preventable diseases.

"We have begun to overcome these difficulties," Dr. Shaw says. "The doctors have come to know their Indian patients—to appreciate their abilities, respect their traditions, understand their needs and make themselves understood."

The U.S.P.H.S. program serves 315,000 Indians in the United States and 35,000 Alaskan natives. His service operates 56 Indian hospitals which are not sufficient to serve populations of such size with unusually high medical care needs and a large backlog of illnesses.

'To meet the needs of the Indians for hospital care where community health facilities are available to provide such services," Dr. Shaw writes, "the Public Health Service makes use of 120 nonfederal hospitals on a contract basis." About 1,500 Indian patients are cared for each day in nonfederal hospitals with such contractual arrangements.

"In carrying out its responsibilities for Indian health," Dr. Shaw adds, "the Public Health Service works in close collaboration with the Indians, state and local governments, the Bureau of Indian Affairs, and community and voluntary organizations. The policy of the federal government looks far into the future toward 'the termination at the appropriate time of federal supervision and services special to Indians.'"

March Trustees' Meeting

At its March 24 (1957) session, the Trustees:

—Instructed the Secretary to communicate with the New Jersey Hospital Association to set a date for a joint meeting to discuss the status of radiology and pathology within hospital organizational structuring.

—Reaffirmed its 1947 action in which it declared that anesthesiology, pathology, physical medicine, and radiology are branches of the practice of medicine; and that:

1. The services of the four groups are medical services.
2. They should be paid for by Blue Shield and not Blue Cross.
3. Physicians affected should render their own bills and should not have their fees paid as part of the hospital bill.

The Board directed that a copy of the communication to the Hospital Association be sent to the secretaries of the Radiologic Society and the Society of Clinical Pathologists.

—Approved a program drafted by the Special Committee on Conservation of Vision.

—Confirmed the appointment of Dr. A.M.K. Maldeis as representative of this Society to a special meeting to develop a glaucoma detection program.

—Agreed to co-sponsor the N. J. Hospital Association's "Institute on Preparation for Community Disaster."

—Ratified the action of the President, co-sponsoring the March Cancer Seminar at the Newark Presbyterian Hospital.

—Designated Dr. Robert S. Garber as our Society's representative to the Middle Atlantic Hospital Meeting's session on psychiatric services in general hospitals.

—Authorized the President to appoint a committee to assist in the development of a plan to assure high quality service, sound administrative controls, and reasonable fee levels, in the operation of the 1957 amendments to the Social Security Law.*

—Received from the Special Committee on Workmen's Compensation a report about the new medical forms. The report follows. Dr. Dilger and Dr. Ruoff were authorized to attend a meeting called by the State Department of Labor to review these forms.

These forms were prepared without consultation with The Medical Society of New Jersey, and thus set a bad precedent for handling of medico-legal problems.

The special committee recommends that a meeting be held with representatives from the Departments of Labor, Self-assured, Insurance Companies, and The Medical Society of New Jersey to devise forms which would be satisfactory to all parties concerned.

The special committee feels that while the injured employee is entitled to the diagnosis, additional matters including medical opinions of possible causal relationship should not be furnished routinely as might be implied by line 18 (a) calling for the physician's report—"Diagnosis of Physician—Give details as to nature and extent of injuries."

—Authorized the President to develop a questionnaire for circulation among medical education committees of county societies to ascertains the profession's interests and wishes with respect to graduate medical education.

—Ratified the President's action signing an indemnity agreement for the furnishing of a $20,000 bond, preparatory to the Federal Government's issuance of $100,000 advance in connection with the Medicare program.

—Approved the issuance of M.D. license plates to an organization renting automobiles, provided that the Director of Motor Vehicles maintained careful control.

—Authorized the President to appoint a physician on the panel advising the Motor Vehicle Director on the licensing of epileptics. Dr. Harrison F. English was subsequently named.

—Authorized the President to name personnel to a tripartite conference on medical-nursing-hospital problems. Dr. Bowers was named as chairman of the group, with Dr. Lance, Dr. Ware and Mr. Nevin as other members.

—Ratified the naming of Louis S. Wegryn, M.D. as representative to the AMA Conference on Veterans' Affairs.

—Named personnel to a joint meeting of the Health Insurance Council. Dr. Daniel

*President Fritts named Dr. Charles H. Calvin chairman of this committee. The other members are Dr. David Eckstein, Dr. John B. Fuhrmann and Dr. Irving Klompus.

Featherston was asked to serve as chairman, with Doctors Hurff, Schaaf, Greifinger and Schretzmann as the other members.

—Approved the following proposal for the publication of annual reports:

That the closing date for annual reports be delayed six weeks, and that such reports be made available to the House of Delegates in mimeographed form or offset printing. If desirable, the reports could be mailed to the House ten days prior to the opening of the annual meeting, and/or copies could also be made available for distribution to the delegates at the first session of the House. The annual reports could then be published in the *Transactions*, along with the proceedings of the House of Delegates. The other items now included in the Transactions could be published in THE JOURNAL. There would be no difference in the cost of the publication of THE JOURNAL or the *Transactions*, and the income of THE JOURNAL would not be reduced in any way. The *Transactions* would be all-inclusive and self-contained since both the reports and actions on them would be in the same brochure.

—Allocated a sum of money for a reception to the incoming President of the American Medical Association on June 4, 1957. The incoming President is our own David B. Allman.

—Approved a budget of $207,975 for The Medical Society of New Jersey.

—Approved a recommended assessment of $40 per member for 1958.

—Took the following action on recommendations of the Welfare Committee:

A-22—Several Trustees expressed the opinion that legislation such as A-22 was premature. While the bill "authorizes" boards of education to require pupils to receive immunization against poliomyelitis as a prerequisite to attendance, the legislation, if passed soon would make such immunization mandatory. The Board directed that the Society's position on A-22 be one of No Action.

A-27 and A-128—It was the opinion of the majority of the Board that the Society's position on these two bills should be the same as our position on last year's measures. The Board adopted the position of No Action on these two measures.

A-219—The Board approved the Society's position of Active Opposition on A-219.

—Approved the Welfare Committee's recommendation on other legislation. See page 299 of this JOURNAL.

—Approved a recommendation that each county society establish a committee "to verify whether a person is really disabled within the meaning of the Social Security Law."

—Approved the following recommendation of the joint committee on Medico-Legal Testimony:

The primary purpose of the meeting was to decide whether, in the opinion of the representatives of the Bar Association and of The Medical Society of New Jersey, a joint committee of the two organizations be set up to pass upon the merits of contemplated malpractice cases. In the original concept, attorneys would be invited to submit their cases to the committee, on a voluntary basis, for evaluation. If the committee felt there was no merit in the case it would so advise, in the expectation—though not in the assurance—that under the circumstances the attorney for the plaintiff would not proceed. If the committee felt that the case had merit, it would so declare and would use its influence to assist the attorney for the plaintiff to get proper medical testimony if such were not readily forthcoming.

Points of criticism had arisen out of a previous conference attended by representatives of the Committee on Medical Defense and Insurance, the chairman of the Judicial Council, the Presidential officers of The Medical Society of New Jersey, and representatives of the Medical Society's insurance carrier. They included:

(1) Opposition by the insurance carrier to the proposal, as hostile to its role in providing protective insurance for members of The Medical Society of New Jersey.

(2) Opposition based upon the fact that the opinions of the joint committee could not be made binding upon either plaintiff or his counsel, with the result that counsel might nevertheless proceed; or in disapproved cases, refusing to proceed, might be dismissed by the plaintiff who would then have recourse to more willing counsel.

(3) Opposition based upon the contention that in cases declared by the committee to have merit, settlement would become more difficult and more costly.

Recognizing these points of opposition as being substantial and formidable, the committee explored the possibility of dealing with the problem by some other means. Many devices were offered and discussed, but against all, three considerations prevailed:

(1) The objection of the insurance carrier would still hold.

(2) Any plans setting up panels of physicians to serve at the call of the Society, or of the court, would be invasive of the individual physician's right freely to choose to testify or not; and

(3) No plan could be drawn up which would be made binding upon the plaintiff or his counsel.

Finally, by unanimous agreement the joint committee declared: "This committee has explored all seemingly feasible approaches to solution of the problem and can arrive at no workable solution." *The joint committee therefore agreed to recommend that the proposal be abandoned.*

The committee also asked The Medical Society of New Jersey to agree that the "study of medical testimony in compensation courts on a statewide basis" be held in abeyance and referred to next year's committee. This request was approved.

The committee asked The Medical Society of New Jersey for permission to defer its report on *Codes of Standards of Practice Governing Lawyers and Doctors* until such time as it can be completed by the committee next year. Because the time this year was taken up almost exclusively with testimony in malpractice cases, the committee did not find it possible to give adequate time to carrying out the directive contained in the resolution of the 1956 House of Delegates, to wit:

> Resolved, that The Medical Society of New Jersey institute the necessary committee to work in liaison with a committee of the New Jersey State Bar Association to formulate such a code which is to be presented and voted upon at the next annual meeting of this Society.

At the reorganization meeting of the Board of Trustees May 15, 1956, it was reported that the International Ladies Garment Workers Union decided to set up a New Jersey program largely modeled after G.H.I. of New York. In a preliminary meeting with Dr. Schaaf, they sought unofficial assurance that The Medical Society of New Jersey would approve such activities in general and the proposed Board of Trustees such a plan in particular. Such approval is mandatory under New Jersey statute.

The Board of Trustees appointed a special committee (Dr. Greifinger, Chairman; Dr. Kump, and Dr. McCall) to meet with representatives of organized labor, consult with counsel, and confer with those interested in setting up the plan.

The chairman made several attempts to arrange a meeting with representatives of the International Ladies Garment Workers Union, but was unsuccessful. Therefore, no further steps have been taken by the special committee to carry out its instructions.

—The Board approved the following report from the chairman of a special committee, Dr. Schretzmann:

My special committee to study the plan of The Medical Society of Pennsylvania for defense of members in appeal to higher courts, met and discussed the problem thoroughly. We had the Pennsylvania plan before us and noted that they make provision for supplying attorneys to defend their members in court action. However, they do not make provisions for paying for judgments.

Our committee decided that further study of the problem should be made in conjunction with the findings of Dr. Featherston's special committee which is studying its problem at this time, and has not yet come up with a definite conclusion. At present it was the consensus that the physicians will be best protected by adequate professional liability insurance coverage.

This should be further studied and is important for our profession. This is especially true because of the unwarranted high judgments which are occasionally rendered in malpractice cases. If it is the wish of your Board of Trustees, I would be most happy to offer my services in the continuance of the study of this problem.

—Approved and certified the following amendments to the Schedule of Allowances under the Medicare project:

In negotiating the contract a single amount was established for each type of cesarean section, to include not only the surgical operation but also antepartum and postpartum care. The Government requested an amendment to provide for the compensation of a physician who performs a surgical operation and postpartum care only. The committee proposed the following sentence to the Government for inclusion in the Schedule of Allowances: "When antepartum care is not rendered by the physician performing the surgical operation and postpartum care for procedures Nos. 4801, 4802, 4803, 4804, or 4805, the amount established for that procedure will be reduced by 50 per cent of the allowable antepartum care, or $25."

The Government submitted an amendment to the joint directive which provides that the payment of $15 by the patient for outpatient care will be limited to the physician's charges. Accordingly, it will no longer be necessary for a physician to include a hospital's charges on his statement for outpatient facilities which he submits for compensation under the program. Instead, a hospital now may submit its statement directly to its fiscal agent. Similarly, a physician will submit his claim form for charges in excess of the $15 which he will collect from the patient. The change will eliminate an undesirable billing procedure and should materially permit the effectual implementation of the program.

Haddon Hall Highlights

Spent so much time in that Viking Room on the 13th floor that we memorized the frieze of Norse names that repeated itself endlessly around the border. Gorm . . . Fridthjof . . . Herald (One "R") Bluetooth . . . Halfdan . . . Odin . . . Gorm . . . Fridthjof . . . and so on . . . and on. By all odds, our favorite Viking is Herald (One "R") Bluetooth. The House had its fourth parliamentarian in four years. Expendable item. Also, something new: a Speaker. The Speaker doesn't make speeches. The title means "spokesman" not "speech maker." David ("3 Hat") Allman gave the Key to Atlantic City to Lew Fritts . . . said it would open any door in the World's Playground . . . but to keep him out of too much door jumping, he also gave an Atlantic City Detective Badge to Albert Kump.

Saturday night was the usual open season on Medical-Surgical Plan. A bevy of MSP officials, looking very handsome, but remaining largely mute, decorated the rostrum. Most of the shots were received and returned by the Old Maestro himself without disturbing the men in the backfield. Item, is ingrown toenail a catastrophic illness? Item, why is a gastrectomy worth more than a prostatectomy?† Whether they came from the center or from way out in left field, Roy Schaaf fielded them all.

Espionage agents report strange doings in Vincent's Hideaway: the cavern where the Nominating Committee met. In addition to the usual concern about second vice (they never worry about the first vice) there was the mystery of the vacancy in the Publication Committee. Dr. Evans asked not to be renominated. The Committee, Dr. Mott present, then nominated Dr. Mott to the Publication Committee. The gimmick: Dr. Mott was already on the Publication Committee but was too modest to say so. Result: 2 Motts in one slot —or rather, one Mott in two slots. This parliamentary crisis was neatly overcome by Samuel ("Bring down the House") Sica who had his county's delegate nominate our new Archivist, Fred Rogers, to the empty slot, so now we got one Mott in one slot.

April and May are convention months in Atlantic City. A census of the "Welcome" stickers in boardwalk store windows shows that A.C. was also playing host to the Butcher Workmen of North America, the Knitting Art Exhibitors of the Middle Atlantic Area, the Broachers Club, the U. S. Chiropody Conclave, The Malacologists Society, and the American Underwear Institute.

The third session of the House was the longest in modern times. Before the war, they used to read every Annual Report, and the session might last 18 hours. In those days a delegate needed a prostatic clearance. The Monday session this time was enlivened by Union County which wanted to convert MSP into a cash indemnity plan and which sparkplugged a move to equip every county medical society with its own personal Trustee. The requisite majority didn't agree, but it was good, clean fun. "In Union" quipped Joseph Patrick Donnelly, "In Union, there is disagreement." Actually, Union furnished something besides controversy. They furnished the Speaker of the House, and they furnished Mrs. Bertram Sauerbrunn, who keynoted the Banquet. "In return for our serving as wives, mothers, phone operators and bar-tenders" she said to the doctors, "you have clothed us, coiffed us, and caressed us."

Joseph Patrick Donnelly also traumatized some delicate feelings by telling one small county society that they could hold their annual meeting in a telephone booth. A representative from the small but mighty county so insulted, wanted to know where he could find a booth that size.

One resolution would include in civil defense advisory groups, nurses, dentists, *et cetera*. Charles Jaeckle objected strongly to *et cetera*, and *et cetera* lost. The nurses and dentists stayed. Other bits of excitement included an air raid test, change of time to daylight saving, a mathematical error in computing two-thirds, a call, "I move previous question," and Joe Donnelly's announcement that he agreed with the position of the Essex delegation. Spencer Snedecor (of the exclusive Company of Fellows) was the one who said "I move the previous question." The Speaker and the Parliamentarian knew just what he meant but some of those who voted "yes" on it didn't. The change to daylight saving time caused one reference committee chairman to be late, since his metabolism was still on stand-

†Which would *you* rather have?

ard time. And it caused endless disputes as to whether the delegates gained, or lost, an hour of sleep.*

Then there was the air raid drill in the middle of the long House session on Monday. According to the posters, an intermittent 3-minute blast on the siren was a red alert and meant "Take Cover." But the horns, whistles and sirens shrieked in vain. The House did not take cover.

Monday evening, Dan Featherston conducted a symposium on the doctor as a witness. While one speaker was discoursing on the nature of truth, the Governor of New Jersey walked in, flanked by his personal physician (now known as the Eleventh Trustee). So they found one way of slowing down the speech: put a governor on it. The Governor told of the 4th grader who wrote a composition on Benjamin Franklin. He came to Philadelphia, bought a roll, found a girl, married her: and then discovered electricity! The audience cheered, but confidentially, they would rather have seen Mrs. Bob than Governor Bob. She's prettier.

An unattached participle was found dangling in a resolution. Not a serious solecism, except that this was a resolution urging State Boards to include in each examination "an inescapable device to insure the easy, facile and understandable use of the English language." The dangling participle: "In spite of conducting the State Board examinations in English, a considerable number of applicants have been licensed . . ." What does "conducting" modify? Answer: nothing. It dangles.

Ralph Buchanan walked through the halls of Haddon wearing a campaign button. Since this is a strictly non-political magazine, we will not mention Ralph's candidate for Governor. M. W. Bergman of Newark, announced at the general session that, while a psychiatrist, he was not one of those psychiatrists who was concerned with the vagaries of the human mind. This broke up the session. At the mental hygiene meeting, the speaker, referring to board diplomates, wondered why a doctor had to be "certified . . . like so much sterile milk."

The Kump administration got off to a good start. The long House session on Monday ran well over the lunch period, and by the time the last Reference Committee had been bedded down, everyone was hungry. Then came the moment for Albert Kump to make a sort of inaugural address. He did it in four words: "The meeting is adjourned." Thus the new President endeared himself to the Delegates. They poured out of the room, en route to a delayed luncheon, reading Gorm, Fridthjof Halfdan, Odin, and our favorite Viking, Herald (One "R") Bluetooth.

*They lost it—Editor.

March Welfare Committee Meeting

The Welfare Committee met on March 10, and took the following action on proposed legislation.

Suggested "No action" on S-6, S-26, S-45, S-48, S-66, S-129, A-14, A-22, A-27, A-128, A-169, and A-321.

Suggested "Disapproval" of S-29, S-59, S-60, S-88, S-128, A-84, A-206, A-219, A-245, A-249, A-259, and A-261.

Suggested "Approval of" S-70, S-92, SJR-1, SJR-2, A-3, A-39, A-185, A-207, AJR-1, AJR-5, AJR-7, and ACR-16

Suggested "Approval in principle" or "Approval in purpose and intent" of A-65, A-143, A-211, and A-175.

191st Annual Meeting — April 27 - May 1, 1957

Haddon Hall, Atlantic City

Official Attendance

County	Delegates	Members	Total
Atlantic	10	79	89
Bergen	37	37	74
Burlington	6	20	26
Camden	21	53	74
Cape May	3	5	8
Cumberland	6	18	24
Essex	70	172	242
Gloucester	4	12	16
Hudson	26	40	66
Hunterdon	3	4	7
Mercer	24	50	74
Middlesex	12	36	48
Monmouth	18	44	62
Morris	11	22	33
Ocean	3	9	12
Passaic	22	37	59
Salem	3	6	9
Somerset	6	18	24
Sussex	3	3	6
Union	34	49	83
Warren	3	6	9
Fellows, Officers, Trustees, Councilors	20		20
	345	720	1,065
Physician Guests			99
Physician Exhibitors			38
TOTAL PHYSICIAN REGISTRATION			1,202
Auxiliary Members			370
Visitors			267
Exhibitors			272
TOTAL REGISTRATION			2,111

FIVE-YEAR COMPARATIVE REGISTRATION FIGURES

Year	Physicians	Others	Totals
1957	1,202	909	2,111
1956	1,238	947	2,185
1955	1,040	790	1,830
1954	1,231	996	2,227
1953	1,012	871	1,883

Scientific Exhibit Awards

Class I—Scientific exhibits of individual investigations, judged on the basis of originality and excellence of presentation:

First Place: The Significance of Melituria in Pregnancy
Milton Gross, M.D., Robert E. Sexton, M.D., and Robert I. Dorian, M.D., Margaret Hague Maternity Hospital, Jersey City

Second Place: Pathology of Lung Expansion in the Newborn
Peter Gruenwald, M.D., and Joseph P. Donnelly, M.D., Margaret Hague Maternity Hospital, Jersey City

Honorable Mention: Effect of Metisteroids in Toxemia in Vitro and in Vivo
H. Seneca, M.D., O. K. Troc, M.D., and R. Scheuer, M.D., Columbia University College of Physicians and Surgeons, and Columbia-Presbyterian Medical Center, New York, N. Y.

Honorable Mention: An Evaluation of C-Reactive Protein and S-GO Transaminase in Coronary Artery Disease
Irving G. Kroop, M.D., and Nathan H. Shackman, M.D., Jewish Chronic Disease Hospital, Jewish Hospital, and State University College of Medicine, Brooklyn, N. Y.

Class II—New Jersey Exhibitors:

First Place: Arterial Grafts — Factors Involved in Success or Failure
Norman Rosenberg, M.D., John Henderson, M.D., E. R. L. Gaughran, Ph.D., J. H. Lord, D.V.M., Ph.D., and J. F. Douglas, Ph.D., Middlesex General Hospital, and St. Peter's General Hospital, New Brunswick

Second Place: Cardiac Resuscitation
Anthony D. Crecca, M.D., Joseph V. Crecca, M.D., John J. McGuire, M.D., Lucien G. Massarelli, M.D., and Thaddeus A. Balinski, M.D., St. Michael's Hospital, Newark

Honorable Mention: Blood Volume Determination Using Radioactive Iodinated Human Serum Albumin
Department of Radiology, Vincent M. Whelan, M.D., and Andrew P. Dedick, Jr., M.D.; Department of Medicine, Frank J. Altschul, M.D., and Joel Feldman, M.D.; Department of Surgery, Harold A. Kazmann, M.D., Monmouth Memorial Hospital, Long Branch

Honorable Mention: Clinical Significance of Serum Ammonium Levels in Liver Disease
Abraham L. Friedman, M.D., and Vincent H. Gillson, M.D., Bergen Pines County Hospital, Paramus

Announcements • • •

Pulmonary Disease Symposium

A combination vacation and graduate course is available to you if you register for the symposium for general practitioners on chronic pulmonary disease, to be held at Saranac Lake from July 8 to 12. It is approved for credit by the American Academy of General Practice. Your families are welcome to enjoy the vacation facilities of the Adirondack Mountains and excellent housing accommodations at all prices are available. The registration fee for the whole symposium is $40. For further information write to Dr. Henry W. Leetch, P. O. Box 11, Saranac Lake, N. Y.

Occupational Medicine Course

New York University announces a full-time, eight-week course in occupational medicine, beginning September 16. This covers all aspects of preventive medicine, administrative medicine, occupational diseases and injuries, and industrial hygiene. It includes field trips, lectures, conferences, and seminars. For further information write to Associate Dean, Post-Graduate Medical School, 550 First Avenue, New York 16.

Vertigo Clinic Available

Temple University Medical Center announces a special clinic for the study of the problems of the labyrinth and internal ear. This "Vertigo Clinic" is held each Tuesday and Wednesday at 1:30 p.m. at Broad and Ontario Streets in Philadelphia in the new out-patient building. Patients may be referred by any physician. A complete survey will be made with appropriate hearing and labyrinthine studies. The report will be returned to the referring physician. Up to now labyrinthine disturbance has not been adequately studied and this program is both clinical and experimental.

Vacancies for Physicians

General practitioners are acceptable for several vacancies on the psychiatric and neurologic staff of VA Hospital, East Orange. Waiver of age limit will be considered. GPs will be trained for the work. Salary depends largely on experience and qualification. Communicate with Chief of Professional Services, VA Hospital, East Orange, N. J.

Eye Booklet Available

Your Eyes After Forty is the name of a brochure prepared by the National Association for the Prevention of Blindness. It covers ocular changes that occur in the second half of life. The book is authoritative and acceptable to physicians. Your patient may obtain a copy gratis from the National Society for the Prevention of Blindness at 1790 Broadway, New York 19, N. Y.

Dr. Alfano to Direct N. J. Blue Shield

Appointment of Dr. Nicholas F. Alfano of South Orange as medical director of the Medical-Surgical Plan of New Jersey (Blue Shield) was announced today by Dr. Royal A. Schaaf, president.

Dr. Alfano assumes the duties of Dr. Irving P. Borsher, who is returning to private practice. Dr. Borsher continues as an advisor to Blue Shield.

Born in New York City, Dr. Alfano earned his M.D. degree at George Washington University in 1936. After internship and residency at St. Michael's and Columbus Hospitals in Newark, he served 4 years in the Army.

After the war, Dr. Alfano joined the Veterans Administration, but in 1950 he was named assistant medical director of New Jersey Blue Shield, advancing to associate medical director two years later.

County Society Reports • • •

Bergen

At the regular meeting of the *Bergen County Medical Society* held at Bergen Pines on April 9, with Dr. William T. Knight, President, presiding and 111 members present, the following matters were deliberated and actions taken:

Welcomed to membership eight new members elected in March.

Elected the following to membership: To Associate, Drs. Rudolf Frank, Florence T. McGill; To Regular by transfer, Dr. Maurice B Kagan. Granted leave of absence to Drs. Harry L. Harwood and Louis Reuling.

Received check for $3,027 from Woman's Auxiliary for Medical Scholarship Fund.

Heard announcement of forthcoming membership survey to determine extent of interest in establishing a Medical-Surgical Plan group contract.

Voted to instruct Delegates to The Medical Society of New Jersey to vote in favor of revision of State Society Constitution regarding Trustees.

Adopted a resolution regarding a recommendation by a member which would include in published "Standards for School Health Examinations" approval of private physician medical examination for school children.

Adopted a resolution detailing participation of members in program for Salk vaccine inoculations. One clause included a fixed maximum fee. After the vote, the resolution was moved for reconsideration and placement on the agenda of the next meeting. This took place at a special meeting called by petition of 25 regular members for this purpose only. At the special meeting the resolution was amended to eliminate the stated fixed maximum fee and substitute the phrase "for a nominal office fee."

The Scientific Session was introduced by Dr. Richard B. Berlin. Dr. Berlin presented Mr. Leroy B. Huckin, President of the Bergen County Bar Association, who in turn introduced Mr. Maurice Austin, Secretary of the Bar Association and a panel of five distinguished members of the Bergen County Bar Association; Judges J. Wallace Leyden, who acted as Moderator, and Henry J. Bendheim, attorneys John J. Breslin, Jr., Charles Shenier and William Morrison. Each member presented a five minute discussion of "The Physician as a Witness." The meeting was then thrown open for questions from the floor. Many interesting and pertinent questions, most of which concerned doctor-lawyer cooperation, were discussed freely. It was the consensus that the session had been interesting and instructive and that it had provided many areas for improving relations between the two professions in the county.

CHARLES P. CAMPBELL, M.D.

Reporter

Camden

The regular monthly meeting of the *Camden County Medical Society* was held April 2, at the West Jersey Hospital with Dr. George P. Meyer presiding.

Dr. Elliott C. Shull, president of the Staff of West Jersey Hospital welcomed the Society.

Drs. Charles E. Brimm and Harold A. Speirs were welcomed into the Society upon taking the membership oath and signing the Register.

Dr. Elmer Grimes, chairman of the Program Committee, introduced Dr. William Most who acted as chairman of the scientific portion of the meeting. Dr. Ellis K. Hultzman read a paper on "Hypothermia and its Clinical Applications." Dr. James R. Eynon presented "A Case of Congenital Anomalies About the Umbilicus and its Management." Dr. William Kirkland, by invitation, and Dr. Samuel Geyer discussed three cases of small bowel obstruction; and Dr. August P. Ciell presented "A Case of Sinusitis with Involvement of the Skull."

The secretary read a memoir of the late Dr. Paul M. Mecray, prepared by Dr. David F. Bentley. Dr. Nathan Asbell read a similar one which he had prepared on the late Dr. Harry Feilchenfeld.

Members were advised about the appearance of articles in the "Mail Bag" of the *Camden Courier* concerning socialized medicine. They were advised that the matter had been referred to the Public Relations Committee for study.

Dr. Durham, for Dr. Barnshaw, announced that plans had been made to hold the annual outing at the Tavistock Country Club on June 12.

EUGENE M. KAIN, M.D.

Reporter

Cumberland

The regular meeting of the *Cumberland County Medical Society* was held at Richards Farm, Rainbow Lake on April 9, with the president, Dr. Sherman Garrison, presiding. Thirty-five members were present.

Dr. Sydney Siegel, chairman of the Diabetes Committee, gave his final report on the 1956 Diabetes Detection Drive. Cumberland led all the counties of the state, Statewide, there was a Dreypak return of 15 per cent. Cumberland County distributed 12,000 and realized a return of 2,486 or 25 per cent return. In Cumberland County, there were 37 screened positive cases of diabetes of which 3 were old cases, 9 new cases, 16 not determined and 9 not diabetic. The committee was commended for its scientific study and especially, Dr. Paul Ayars of Port Norris.

The chairman of the Welfare Committee, Dr. Nicholas Marchione of Vineland, gave a resume of disability and social security laws as to doctor-patient relationships.

It has been fifty-two years since our county had presidential representation in The Medical Society of New Jersey. The Society voted to honor Dr. and Mrs. Albert B. Kump at a reception on April 28, at Haddon Hall, Atlantic City.

Dr. Mary Bacon of Bridgeton, was appointed Field Representative of Maternal Welfare for the state.

Dr. Francis N. Campagna of Vineland, was elected unanimously to active membership in the Society.

The newly-elected officers for the ensuing year are: President—Paul K. Ayars, M.D., Vice-President—M. David Baxter, M.D., Secretary — Mary Bacon, M.D., Treasurer—Samuel B. Pole, III, M.D., Reporter—Leonard G. Scott, M.D.

The guest speaker of the afternoon was Henry A. Davidson, M.D., Editor of THE JOURNAL of The Medical Society of New Jersey, Assistant Superintendent Essex County Overbrook Hospital at Cedar Grove; author of *Forensic Psychiatry*; and a national authority on medico-legal matters. His subject was "The Doctor as a Witness." His discussion of medical legal matters was far reaching, thought-provoking, educational and it was most thoroughly enjoyed by all.

The meeting was adjourned for dinner.

LEONARD G. SCOTT, M.D.

Reporter

Gloucester

Gloucester County dentists were guests of the *Gloucester County Medical Society* on March 21, when the Society held its monthly meeting at the Woodbury Country Club. "Oral Lesions" was the topic presented by Lester W. Burkett, D.D.S., M.D., Dean of University of Pennsylvania Dental School. His presentation was enthusiastically received, and all agreed that such combined meetings could do much toward answering common problems of the two professions. Edward Barnes, D.D.S., and President of the Southern New Jersey Dental Association, then spoke to the assembly.

Dr. James Kehler read an invitation from the Gloucester County Bar Association to attend their meeting. President Samuelson appointed a nominating committte for the coming annual election of officers.

Dr. James Kehler, Vice-President, called the monthly meeting to order of the *Gloucester County Medical Society* at the Woodbury Country Club, on April 18. Dr. Lefkoe spoke in behalf of the Gloucester County Cerebral Palsy Association. He paid tribute to Dr. Dorothy Rogers and Dr. William Beall for their sustained efforts in the cause of cerebral palsy. Both were presented with gold watches and a citation which was engraved on a wall plaque.

Dr. J. Antrim Crellin, Clinical Professor of Medicine at the Hahnemann Medical College, gave a talk entitled: "The Internist Looks at the Lung Cancer Problem—An Analysis of 300 Consecutive Tissue Proved Cases."

The Society adopted a motion instructing delegates to vote favorably on proposed amendments to our State Society Constitution. The Society also approved a motion to appoint a paid secretary to take care of the routine business of the society.

The Gloucester County Heart Association announced plans for a course in electrocardiography for members of the Medical Society.

ROGER D. LOVELACE, M.D.

Reporter

Middlesex

Dr. Sidney D. Becker, the president, called the April 17 meeting to order at 9 p.m. The Judicial-Medical Ethics Committee report was given by the Chairman, Dr. B. F. Slobodien. Recommended: From two years of associate membership to regular membership was the application of Dr. Donald T. Akey of Metuchen. This was accepted by the group. The Public Relations Committee report was not available at the time of the meeting.

Dr. Stanley Gadek, Chairman of the 1957 Nominating Committee presented the following slate of officers for 1957-1958: President, Gerard R. Gessner; Vice-President, George J. Kohut, Secretary, Robert Zullo, Treasurer, Reuben Levinson and Reporter, Rudolph G. Matflerd. Board of Trustees; all elected officers—Sidney D. Becker, Charles H. Calvin, Malcolm M. Dunham, Joseph F. Sandella, S. David Miller, William E. Sherman, John Albert Smith and Henry T. Weiner. Medical-Judicial Ethics Committee: B. F. Slobodien, E. J. Tyrrell and J. J. Mann for two (2) years; William E. Sherman and F. M. Hoffman, for one (1) year. Delegates and Alternates were also elected to the House of Delegates for The Medical Society of New Jersey's 1958 Annual Meeting.

1958 Delegate and Alternate to the State Society Nominating Committee: Charles H. Calvin and Edward F. Klein.

The meeting was then turned over to Dr. Leo Taran, Attending Physician, Long Island Jewish Hospital, who gave a provocative discussion of rheumatic fever. This was well received.

The president announced that the Social Outing date was advanced to May 8 and would be held at the Forsgate Country Club with golfing in the afternoon followed by a steak dinner in the evening.

The meeting adjourned at 11 p.m.

MORTON M. KLEIN, M.D.

Reporter

Monmouth

Fitkin Memorial Hospital was host to the *Monmouth County Medical Society* at its regular meeting on April 24, 1957. The meeting was conducted by the president, Dr. John Hardy.

The following were elected to active membership: Drs. Raymond E. Conover, Belmar; Francis E. Gilbertson, Rumson, by transfer from the Medical Society, County of New York; and Frederic B. Western, West End, formerly a member of the Huron County Medical Society, Ohio.

The film *Back to Life* was shown. This dealt with the rehabilitation of the psychiatric patient. Dr. Avrohm Jacobson discussed the subject and answered questions pertaining to the film.

DONALD W. BOWNE, M.D.

Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held at the Medical Society Building. Dr. Abraham Shulman, the president, opened the meeting.

The Nominating Committee presented the nominees for Delegates and Alternates to the Annual Meeting of The Medical Society of New Jersey. The following were elected for a three-year term (1957-1958-1959):

Delegates

Ben W. Berner, M.D.
Paul B. Ferrary, M.D.
Joseph M. Keating, M.D.
Dorothy Klughaupt, M.D.
David B. Levine, M.D.
Leopold E. Thron, M.D.
R. R. Goldenberg, M.D.
Irving R. Hayman, M.D.
Sandor A. Levinsohn, M.D.
Frank A. De Dominicis, M.D.
Andrew F. McBride, Jr., M.D.

Alternates

Alphonse Del Mauro, M.D.
Norman M. Dingman, M.D.
James R. Lamauro, M.D.
Eugene Kennedy, M.D.
David I. Canavan, M.D.
James P. Morrill, M.D.
H. Eugene Reading, M.D.
Charles H. Hall, Jr., M.D.
Ralph C. Yeaw, M.D.
Gordon W. Howe, M.D.

Nominating Delegate: Joseph E. Mott, M.D.
Alternate Delegate: Joseph M. Keating, M.D.

Dr. Joseph R. Jehl reported on a meeting he had attended of the Committee on Constitution and By-Laws of The Medical Society of New Jersey. He felt that in the revisions and amendments to the Constitution, two were of great importance. One was in connection with additional members on the Board of Trustees for better representation, and the other relative to a change in personnel for presiding at the Annual Meetings.

The president requested the members to aid the Woman's Auxiliary by giving the information required for the biographic sketch survey for The Medical Society of New Jersey.

Dr. Michael L. Lewin was called upon to explain and read the resolution presented by him in connection with the Crippled Children Commission, urging the Governor of New Jersey to appoint a commission to examine the scope, activities and the structure of the Crippled Children Commission and draft appropriate legislation.

It was moved that the resolution be accepted and sent to The Medical Society of New Jersey for action, after it had been edited by the Welfare Council. The motion was carried.

Dr. A. Gerard Peters presented the speaker, Harold Jeghers, M.D., Director, Department of Medicine, Seton Hall College of Medicine.

At the conclusion of the question period, a collation was served.

The regular monthly meeting of the *Passaic County Medical Society* was held on April 16 at the Medical Society Building. Dr. Abraham Shulman, the President, called the meeting to order.

The following physicians were elected to Associate membership: Dr. Stephen P. Ferraro and Dr. Morton Kass, both of Paterson.

Proposed revisions to the Constitution and By-Laws of this Society, published in April 1957, were approved and made a part of the Constitution and By-Laws of the Society.

The President asked for the support of the members for Dr. Joseph R. Jehl as nominee for Second Vice-President of The Medical Society of New Jersey.

The President read communications from the Essex and the Union County Medical Societies, both of which referred to the amendment to the Constitution of The Medical Society of New Jersey, to provide for an elected trustee by and from each County.

After a short discussion, it was voted that the Society approve this proposed amendment, and that the delegates of the Passaic County Medical Society be so instructed.

The President spoke about a communication from the American Cancer Society, urging physicians to respond generously during the Cancer Society campaign. Dr. Shulman said that the Society should not conduct campaigns for any funds, the members individually should contribute, as citizens, to such worthy campaigns.

The meeting was then turned over to Dr. Henry R. Shinefield who introduced the speaker, Walter L. Henley, M.D., of Mount Sinai Hospital, New York City. Dr. Henley's topic was "Newer Viruses and their Clinical Applications."

After the question period, a collation was served at a table attractively arranged in keeping with the April holidays by the hostess, Mrs. Eugene T. Kennedy, President of the Woman's Auxiliary.

DAVID B. LEVINE, M.D.

Reporter

Salem

Officers for the coming year were elected at the April 19 meeting of the *Salem County Medical Society* held at the Du Pont Penns Grove Country Club. The panel presented by the nominating committee was unanimously elected: *President*, Dr. W. Garrett Hume; *Vice-President*, Dr. Charles E. Gilpatrick; *Secretary*, Dr. George Nitshe; *Treasurer*, Dr. Donald A. McLean; *Reporter*, Dr. William L. Sprout. Councillor members of the executive committee will be the three immediate past presidents, Drs. C. B. Norton, Eugene T. Pashuck, and Isadore Lipkin.

Dr. Hume reported on the March 12 meeting of the Council for local Public Health Services, and the Society voted to join the council as a group. He also announced plans for the society's annual Shad Dinner to be held May 18. Dr. Nitshe discussed the problem the incoming treasurer would face in renewing the society's enrollment in the Hospital Service Plan of New Jersey. The society voted to instruct the treasurer to declare the yearly premium due October 1 and delinquent November 1, so that the list of delinquent members may be published in the November issue of the *Bulletin* and premiums collected by December 1, so that the Blue Cross protection of the other members may not be jeopardized.

Dr. Gilpatrick reported an increase of $5 in the proposed annual assessment per member by The Medical Society of New Jersey; he was instructed to protest this. Delegates to The Medical Society of New Jersey were instructed to vote against this increase unless information convincing them of its necessity is presented. The delegates were also instructed to vote for the proposed amendment to the Constitution of The Medical Society of New Jersey providing for a trustee from each county.

A report was presented from Dr. Madara on the testimonial dinner in honor of Dr. William T. Hilliard held March 16 at the Salem Country Club. More than 200 persons attended, including representatives of the Society and the Rotary Club of Salem. Dr. Hilliard will be further honored on April 28 at the Annual Meeting of The Medical Society of New Jersey by becoming one of the first recipients of the society's Golden Merit Award for fifty years of active medical practice.

W. L. SPROUT, M.D.

Reporter

Obituaries • • •

DR. EARL S. HALLINGER

Hundreds of physicians in this state will recognize the name of Earl Hallinger—it appeared for years on licenses to practice medicine. Dr. Hallinger was, for 16 years, secretary of the State Board of Medical Examiners. During that period he signed 2150 licenses.

Born in Camden in 1880, he was graduated in 1903 from the Hahnemann Medical College. He returned to Camden for general practice but became increasingly interested in otology and laryngology. For a quarter of a century he was chief of that service at the West Jersey Hospital. He later moved to Haddonfield. He was, at one time, president of the New Jersey Homeopathic Medical Society. On April 28, The Medical Society of New Jersey honored him with a Golden Merit Award. And on May 7, he suffered a stroke and died. Dr. Hallinger was also a Fellow of the American College of Surgeons.

DR. JOSEPH WANTOCH

Having served the people of Carteret for over half a century, Dr. Joseph Wantoch died there on April 19. Born in Czechoslovakia in 1882, Joseph Wantoch was taken to Newark, N. J. at the age of 7. After attending the public schools of Newark, he went to college at Richmond, Virginia and in 1904 received an M.D. degree from Wayne University in Detroit. He interned in New York and came to Carteret in 1906. He was a busy staff member at Perth Amboy General Hospital from 1918 to 1949. Dr. Wantoch was a family doctor in every sense of the word, and he was active in civic and fraternal affairs in Middlesex County. Dr. Wantoch was a useful and valued member of the Middlesex County Medical Society.

Mrs. John C. Voss



Born Margaret Elizabeth Lee in 1912 in Douglasville, Pennsylvania, our new State Auxiliary President, Mrs. John C. Voss, of Riverton, received her formal education in the public schools of her native state.

In 1933 she was graduated from the School of Nursing of Philadelphia's Lankenau Hospital. She did graduate work at Philadelphia Lying-In Hospital and at the University of Pennsylvania. From 1935 to 1942, she held supervisory positions in Lankenau Hospital and Zurbrugg Memorial Hospital in Riverside, N. J. There she met John C. Voss, M.D., a graduate of Temple University School of Medicine and a member of the Burlington County Medical Society.

They were married in 1942 and have five children: Henry, 14; Nancy, 13; Linda, 10; John, Jr., 8; and Stephen, 6.

Peggy, as she is known to us, has been active in Auxiliary affairs since she joined the Burlington County group in 1942. She served as its able president from 1949 to 1950. She became a member of the Executive Board of the Woman's Auxiliary to The Medical Society of New Jersey in that year and has served continuously ever since in many positions of rising responsibility.

Many other local organizations claim Mrs. Voss' time and efforts. At the present time she is vice-president of the Board of Trustees, Burlington County Guidance Center, and a director of the Mental Health Association of Burlington County. She is also the Freeholder-chosen member of the Managing Committee of Evergreen Park Hospital. Only recently she concluded service on the Riverton Board of Education.

Peggy adds that one hobby and her chief relaxation is working with young riders and their horses. She has a four year old Palomino mare which she has raised from a colt. She has trained it with some help from the children. She hopes to acquire another horse in the near future.

This sketch paints a portrait of a very busy mother, homemaker, and leader in community activities devoted alike to young people and to furthering the aims and objectives of her husband's profession.

But the black and white printed words do not convey to the reader the real warmth of Margaret Lee Voss. For all those who come in contact with her, she is a *friend* whose portrait could be painted in all the glowing colors and endearing qualities that the word implies in its truest meaning.

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Surgery in World War II. Edited by J. B. Coates, Jr., M.D. and M. E. DeBakey, M.D., Washington, D. C. 1956. Office of The Surgeon General, Department of the Army. Government Printing Office. Pp. 447. (Volume 2: General and Traumatic Surgery) ($4.25)

War has taught us many medical lessons. In no field is this more manifest than in surgical trauma. Although the primary interest of the medical department of the United States Army was the *immediate* care of the wounded it was soon realized that established surgical practices had to be re-evaluated and newer ones critically and statistically analyzed if mortality and morbidity were to be reduced. During the long African-Italian campaign (1942 to 1945) the 2d Auxiliary Surgical Group with the assistance of hospital units headed by the chiefs of surgery from United States and European medical centers collected and analyzed the data of 3,154 abdominal wounds upon which this book is based.

In this magnificent analysis every phase of handling the patient with an abdominal injury is presented in easily read, concise and logical form. Resuscitation, control of pain and anesthesia are covered in a separate section. Colostomy, which became official practice for injuries of the large bowel in 1943, is particularly well presented. The treatment of individual organ injuries is thoroughly evaluated. Summaries of the data and conclusions with tables and numerous illustrations enable rapid comprehension of the material. Every medical practitioner will be better for having learned the lessons spelled out here. Every surgeon will want this book in his library.

PETER O. GARNER, M.D.

Current Therapy 1957. Edited by Howard F. Conn, M.D. Philadelphia, 1957, Saunders. Pp. 731. ($11.00)

In medical practice, treatment is the pay-off. Pathology, differential diagnosis, etiology and prognosis are all interesting and important. But if the healer cannot heal, he fails. In spite of the priority importance of therapy, a large proportion of medical writing is devoted to other aspects of the science and practice of our profession.

Here is a king-size book focussed squarely on treatment. It is divided into fifteen principal sections, like infectious diseases, diseases of the nervous system, diseases of nutrition and so on. Within each group, the major syndromes are arranged alphabetically and treatment technics are briskly spelled out: one, two, three. The program in each case is labelled "Methods of Dr. So-and-so" (naming the contributor). Some authors use trade names, some use generic names, some use both, so that considerable confusion is produced when you try to compare treatment methods. A useful, alphabetically ordered drug roster in the appendix gives the generic names for the trade names, but not the reverse. The author in one place advises you to use Pagitane® and by consulting this appendix, you learn that this is the proprietary name for cyclimine. Unfortunately there is no listing by generic names. Thus, you are advised to use reserpine, but the drug roster does not list it that way, although the trade name Serpasil® *is* found in its own alphabetical place. (Not however, the other proprietary rauwolfia alkaloids). It is too bad the editor did not adopt a consistent policy about drug names.

Surgical procedures are also briefly described. The appendix includes several useful tables. Although a bit dogmatic in spots, the book as a whole is a valuable and useful reference tool for the medical practitioner.

ULYSSES FRANK, M.D.

Manual of Recovery Room Care. Edited by John M. Beal, M.D. New York, Macmillan, 1956. Pp. 111. ($3.75)

When the new operating theater of the New York Hospital was opened in 1907 there were set aside two rooms on opposite sides of the corridor, and in full view of the passing nurses and doctors, for the care of the noisy recovery from open drop ether anesthesia of "public ward" patients. It soon became evident that this was the place to treat postoperative shock, to start parenteral fluid therapy and to watch for complications. It was later realized that concentration of immediate postoperative care in one physical location made it easier for anesthetist and surgeon to visit patients who would otherwise be scattered throughout the hospital. By 1948 it was reported that "It is only equitable that the private room and semi-private patients receive the same quality care as ward patients." The reporting committee then said: "An adequate recovery room is a necessity to any hospital undertaking modern surgical therapy."

This book, by the Cornell Medical Center group, lists criteria for suitable space and for determining the physical requirements for a recovery room service. Also emphasized are such problems as number of beds required relative to number of

operations daily, arrangement of beds for observation purpose, and lighting and communications equipment. Dr. Beal tackles such problems as selection of patients requiring recovery room service, the handling of visitors, the role of the privately employed nurse, the separation of patients as to private room, private ward, public ward and sex, and the matter of financing the recovery room.

The authors say: "Certainly, the more efficient use of personnel and equipment, the greater safety to patients and the reassurance to their families, which such a concentration of efforts assures, and the avoidance of transporting and dispersing of non-reacted, or partially reacted postoperative patients, throughout the hospital are factors which merit the attention of economy minded and public relations-wise administrators."

Duties of the recovery room supervisor are discussed. An in-service educational program to be given by doctors, anesthesiologists and nurses is proposed. Also elaborated here are intravenous fluids and technics, immediate postoperative complications and cardiac arrest.

Dr. Hayes, discussing intravenous fluids, states (1) "Recovery room personnel are concerned with starting and maintaining the flow of intravenous fluids and blood." (2) "The intravenous route is associated with more dangers than other methods of administering substances;" and (3) "The patient is at the mercy of the individual who places a needle in his vein."

Every hospital with a recovery room should have this treatise on its reference bookshelf. Hospitals which have not yet established such a service will find good guidance in this practical work.

V. Earl Johnson, M.D.

Other People's Children. By Anna V. Levy, Judge of the New Orleans City Court. New York, Ronald Press, 1956. Pp. 287. ($3.75)

For almost a decade, Mrs. Levy was Judge of the Juvenile Court in New Orleans. Out of that experience she has distilled this book. She uses the case study rather than the statistical method of presentation. Before the reader, as before the Judge, pass a parade of juveniles. There is not a dull story in the lot. When you finish, you are left with renewed respect for juvenile courts, probation offices, and of the complexity of the problem. How simple to say that all the child needs is kindness and understanding. How simple to say that all he needs is an old-fashioned paddling in a wood-shed! But as you read these stories, your complacency is shaken and out of such shaken complacency may come progress in helping other people's children, and maybe your own too. In an epilogue, Judge Levy soberly analyzes the problem and reviews possible methods of solution. No panacea is offered.

Joseph Santangelo, M.D.

Getting Ready for Parenthood. Mario Castallo, M.D. New York, 1957, Macmillan. Pp. 192 ($3.95)

In spite of all our public education, pregnancy and child-birth are still anxiety-provoking mysteries for many new fathers and mothers. In this slender text, Dr. Castallo explains in sprightly, witty and accurate fashion the facts of life as the parent ought to know them. He discusses the anatomy and physiology of gestation, the rules for a comfortable pregnancy, natural childbirth, convalescence and the puerperium and the care of the newborn. There are good illustrations of the anatomy and physiology of pregnancy. The inside cover of the book has space for recording hospital's and doctor's phone numbers and for making lists of questions to ask the doctor. This is a warm and useful book, *Getting Ready for Parenthood.* Now if someone will only write a book on "How to Survive Parenthood," we will all be happy.

Victor Huberman, M.D.

Organized Home Medical Care: Published 1956 for the Commonwealth Fund by the Harvard University Press. Cambridge, Mass. Pp. 538. ($8.00)

With the conquest of acute illness expected any year now, the medicine of the future is the medicine of chronic disease. Unless hospitals install rubber walls they will not be able to accommodate the rising tide of chronically ill patients. One way of reaching this vast patient reservoir is by providing medical care in the home. This book is a study made by the Hospital Council of Greater New York. The Council analyzed 19 home care programs. They found that most of the patients were elderly and that most of them had been wage earners until immobilized by the illness for which they were getting home care. Cardiovascular disease, apoplexy and diabetes together account for about 70 per cent of the patients in the program. While 90 per cent of the patients preferred home care to hospitalization, it is a toss up whether their young children (or grandchildren) living home with the patients are better off.

The survey revealed heavy loads on the attending physicians with frequent changes of doctors and only indifferent professional supervision. Conscientious visiting nurse service with superior professional supervision and coordination was found. The book also reports on sources of referral, type of program, reasons for rejection, financing, administrative technics, laboratory utilization and relationship to medical schools. Detailed recommendations are included. The whole story is a potentially exciting one and it is told here with less dullness than might be expected.

Henry A. Davidson, M.D.

TUBERCULOSIS Abstracts

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The Crossing of the Curves: Tuberculosis and Lung Cancer

By Edward Kupka, M.D., and Lester Breslow, M.D., Diseases of the Chest, January, 1957.

● Among the serious chronic pulmonary diseases, cancer of the lung is challenging tuberculosis in frequency and has already surpassed it in mortality. Essentially the same case-finding, diagnostic and surgical machinery can be employed against the two diseases. Cancer of the lung is revealing an epidemiologic pattern which may prove helpful in the understanding and control of the disease. No obscure lung disease can be considered as satisfactorily assessed until cancer and tuberculosis have been excluded.

Introduction

The decline in tuberculosis mortality and the sharp rise in lung cancer mortality have led to a "Crossing of the Curves." By 1950 in California primary cancer of the trachea, bronchus and lung was causing more deaths than tuberculosis among persons 65 years of age and over. By 1954 lung cancer deaths exceeded deaths from all forms of tuberculosis in the whole population.

Since 1930 tuberculosis mortality has dropped to one-tenth of its rate at that time. The respiratory cancer rate meanwhile, has more than trebled with lung cancer comprising an ever larger proportion of the total.

DEATH RATES PER 100,000 POPULATION, CALIFORNIA

	1930	1954
Tuberculosis, all forms	99.1	9.8
Tuberculosis, respiratory	88.4	9.0
Cancer, respiratory system	5.2	17.9

Factors in Reduction of Tuberculosis Mortality

Two groups of factors have contributed to the decline in tuberculosis mortality. First are the medical developments and second the general improvement in standard of living. Together they have accounted for a steady decline in tuberculosis mortality. The addition of antibiotics and other potent drugs to the therapeutic resources has accelerated the rate of decline. The annual incidence rate has likewise decreased, but at a less rapid rate. The tremendous expansion of x-ray survey programs has increased the proportion of known tuberculosis, but since in the U.S. there are still an estimated 150,000 unreported and largely undiagnosed and unsuspected persons with active tuberculosis diagnostic activities and propaganda for more frequent x-ray films must continue unabated.

A gradual change in the differential diagnostic problem is evident. In past years, tuberculosis was found more commonly on the chest film than all other serious chronic lung conditions combined. Today, lung cancer and lung suppuration challenge tuberculosis in frequency.

Factors in the Increase of Lung Cancer Mortality

Because so few patients with lung cancer survive even with treatment, the age-adjusted mortality rate remains the best measure of the disease. This rate is still increasing rapidly. Improved methods of diagnosis account in part for the rise in lung cancer deaths. However since 1940, the mortality rate for men in California has increased 147 per cent while that for women has been only 29 per cent.

Three sets of factors have been suggested to account for the increase and present data indicate that each of the three play a role in the development of lung cancer. Many studies have disclosed a greater frequency of cigarette smoking, especially heavy cigarette smoking, among patients with lung cancer as compared with controls. Several occupations have been incriminated, particularly those involving exposure to certain metallic substances or fumes. In this country carcinogenic substances have been isolated from polluted city air.

In evaluating the carcinogenic effects of envir-

onmental agents one must bear in mind the time factor. The evidence suggests that environmental factors lead to human cancer only after many years of exposure. Hence, the rise in lung cancer mortality during the period 1930-1960 may reflect environmental factors during the first half of this century. Likewise the environmental changes during recent years—*e.g.*, vast increases in cigarette smoking among women and among young people of both sexes, entry of hundreds of thousands of persons into such occupations as welding, the heavy air pollution of certain cities —may portend a continuing increase in lung cancer mortality during the latter half of this century.

Tuberculosis and Lung Cancer Mortality Patterns

The male predominates in mortality from both conditions. The ratio is about three to one in the case of tuberculosis, and five to one in lung carcinoma.

Tuberculosis, formerly a disease of adolescents and young adults predominantly, has now become a disease of middle aged and older persons predominantly. Lung cancer, too, is a disease of the middle and later years of life.

Tuberculosis is especially prevalent in slum areas, among poorly nourished persons, and among those living in contact with infectious cases. Lung carcinoma is more scattered in this distribution; housing and nutritional factors seem to play little, if any, role.

Diagnosis and Treatment

Ordinarly, an x-ray film of the chest is the earliest method of detecting either disease. However, certain forms of tuberculosis and carcinoma cannot be easily differentiated on the film. In fact, the x-ray film usually cannot be considered definitely diagnostic unless supplemented by laboratory methods and histologic examination. In the case of tuberculosis, the demonstration of tubercle bacilli is definitive. In the case of carcinoma, biopsy or cytologic examination may give the answer. Every clinically silent lesion casting shadow on the chest x-ray film must have tuberculosis and carcinoma ruled out before any other diagnosis can safely be made. Resection of lung containing a small cancerous nodule in a person in apparently good health represents a triumph of preventive medicine.

The organization and technical machinery originally set up for tuberculosis can be and is being used increasingly to attack the problem of cancer of the lung. The same skills are necessary for diagnosis and treatment. As time goes on the epidemiology of cancer of the lung will assume a larger importance, and this will concern all health departments.

Epidemiologic Approaches to Control

The final conquest of tuberculosis depends upon preventing the transmission of infection from one person to another. Elimination of slums, the examination of every contact of tuberculosis cases, the x-ray film examination of every hospital and prison admission and the isolation of infectious persons will cut so many chains of person-to-person infection that virtual disappearance of the disease may be hoped for.

The factor of resistance is a very important one in tuberculosis. Improvement in general health and lessened crowding make transmission less likely. A significant factor in tuberculosis control is alcoholism which reduces resistance and increases chances of transmission.

No dependable data are at hand regarding the role of smoking in tuberculosis. However, respiratory trauma, which is inevitable in a coughing, compulsive smoker, probably decreases the ability of pulmonary tissue to defend itself against the tubercle bacillus. On the other hand, overwhelming epidemiological evidence now indicates that cigarette smoking is an important causative factor in lung cancer.

Further studies should be carried out. Even more needed is epidemiologic study of air pollution and occupations as causative factors in lung cancer. It is conceivable that cigarette smoking may have been the most important causative element in the increasing mortality from lung cancer up to the present time, but that other environmental factors may be active and more so in the future. Laboratory studies should be carried out to isolate the specific substances in the environment and the mechanics of action.

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Ferrer, F. P., and Boyd, L. J.: Am. J. Dig. Dis., 22:272, 1955

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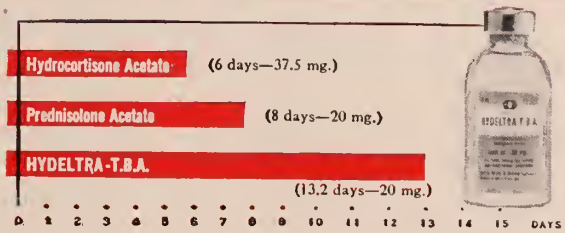
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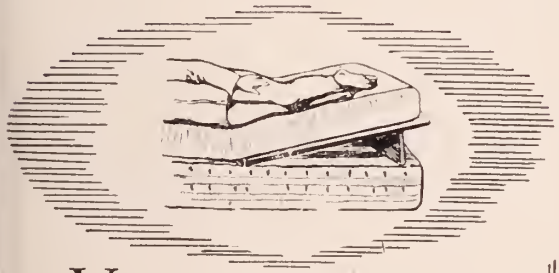
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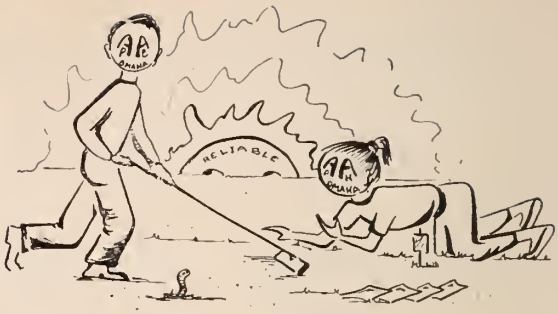
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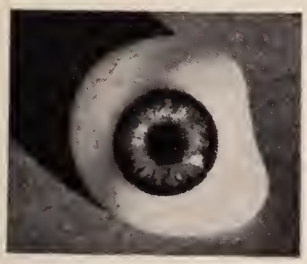
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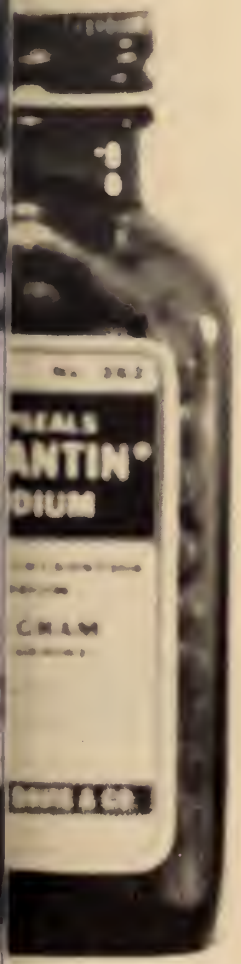
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1. Zimmerman, F. T., and Burgemeister, B.: *Arch. Neurol. & Psychiat.* 72:720, 1954.
2. Zimmerman, F. T., and Burgemeister, B.: *J.A.M.A.* 157:1194, 1955.
3. Zimmerman, F. T.: *Arch. Neurol. & Psychiat.* 76:65, 1956.

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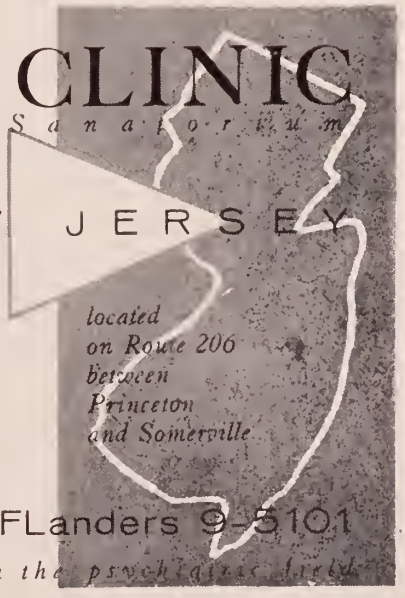
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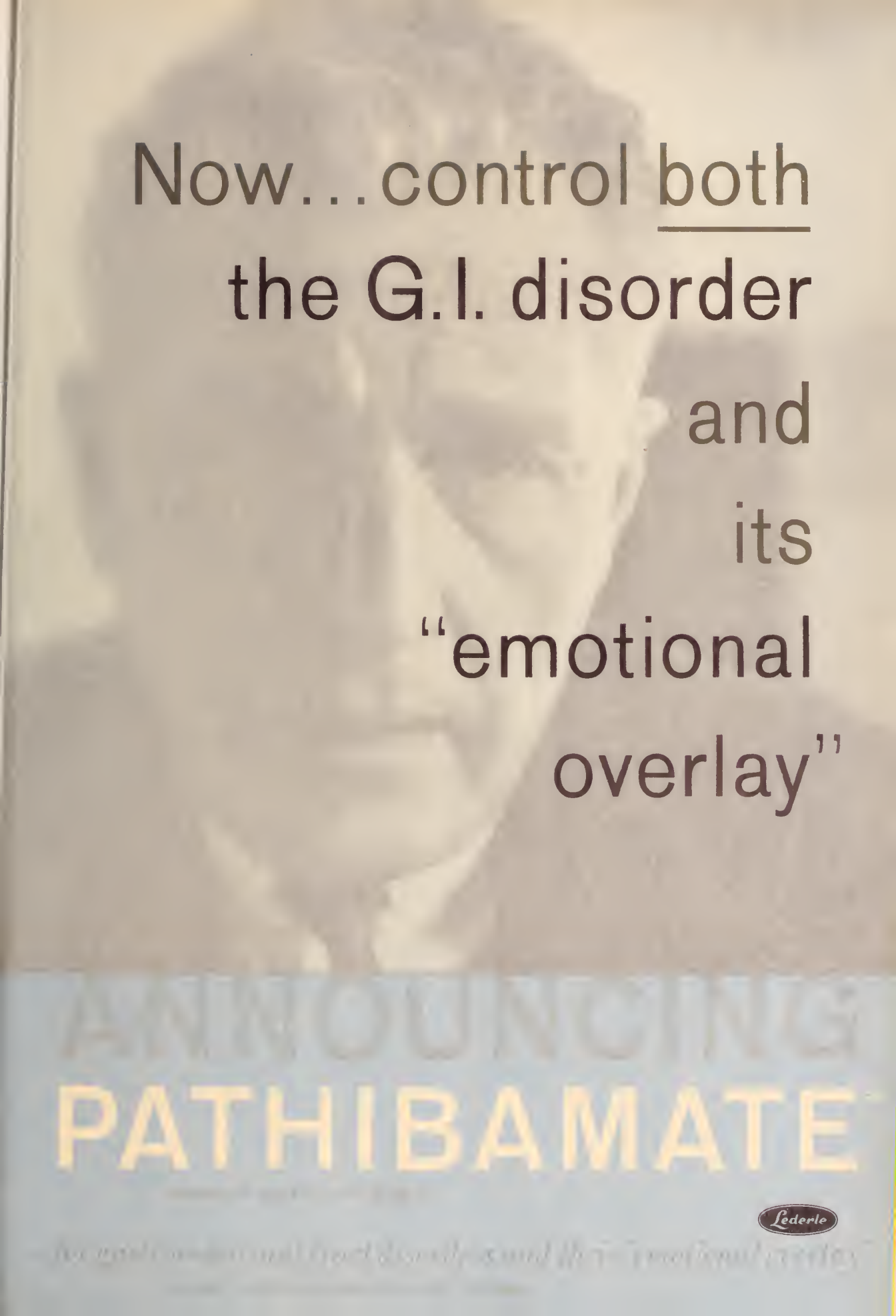
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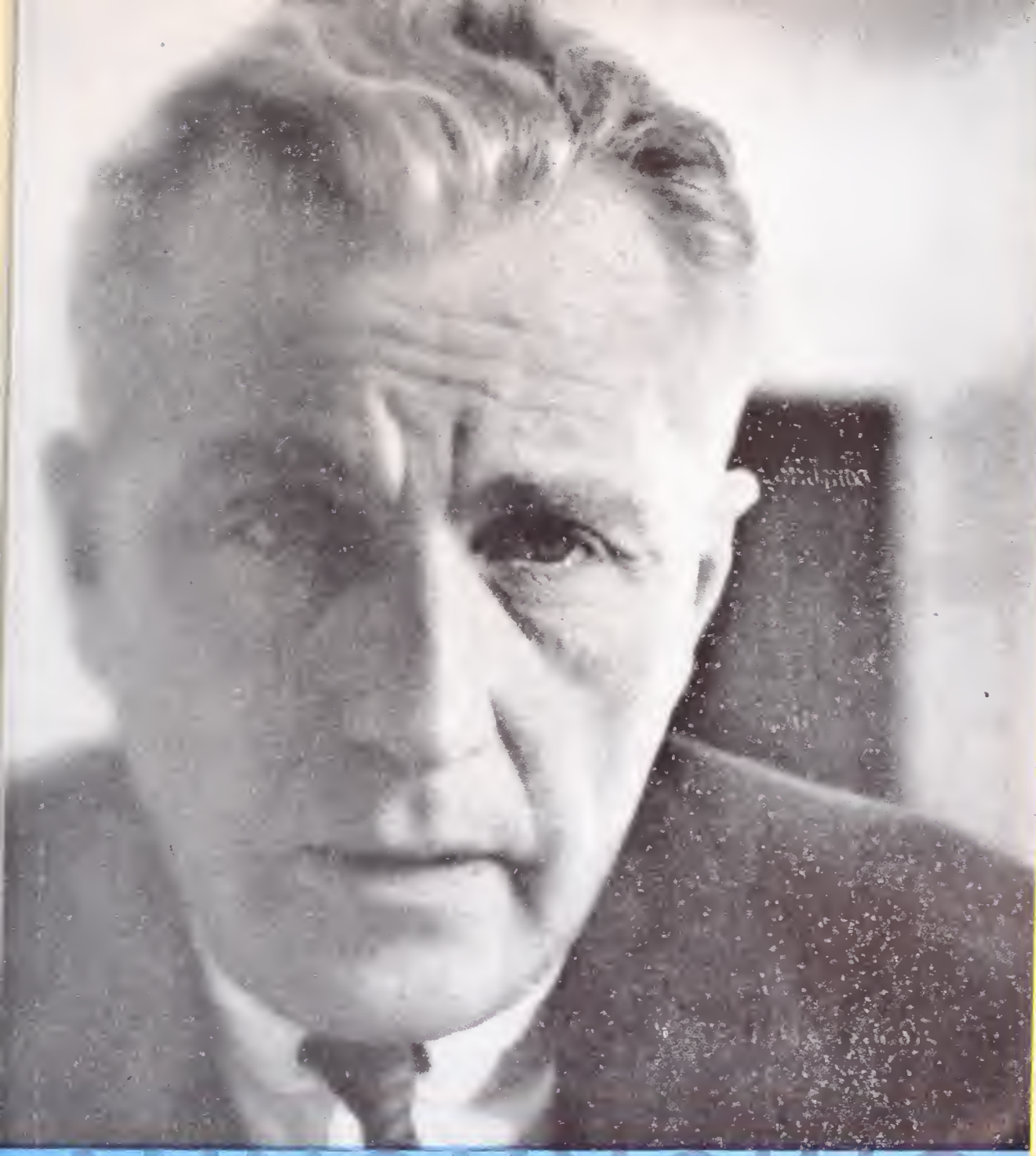
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eferences: 1. Borrus, J. C.: *M. Clin. North America,* press, 1957. 2. Gillette, H. E.: *Internat. Rec. Med. & G. P. in.* 169:453, 1956. 3. Pennington, V. M.: *J.A.M.A.,* press, 1957. 4. Cayer, D.: Prolonged Anticholinergic herapy of Duodenal Ulcer. Am. J. Dig. Dis. 1:301-309 uly) 1956. 5. McGlone, F. B.: Personal Communication to ederle Laboratories. 6. Texter, E. C., Jr.: Personal ommunication to Lederle Laboratories. 7. Bauer, H. G. nd McGavack, T. H.: Personal Communication Lederle Laboratories.

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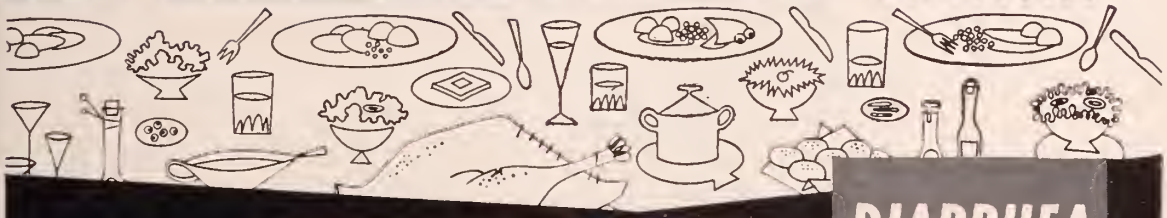
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1	12	13	2½	4	6	390
2	15	13	3	4½	6	480
3	17	9	3	5	5	520
4	20	11	3½	6	5	610
5	23	11	4	6½	5	700
6	26	10	4	7	5	760
7	28	11	3	7½	5	740
8	30	11	2½	8	5	750
10	32	9	2	8	5	760

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Age Months	Weight Lbs.	Evap. Goat's Milk Oz.	Water Oz.	KARO Tbsp.	Each Feeding Oz.	No. of Feedings in 24 Hrs.	Total Calories
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1	8	8	16	2	4	6	395
2	10	9	14	3	4½	5	520
3	12	10	15	3½	5	5	590
4	14	12	18	4	6	5	695
5	16	12	21	4	6½	5	695
6	17	13	22	4	7	5	730
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10	21	16	16	1	8	4	730

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1	8	16	3	4	6	532
2	9	14	3	4½	5	576
3	10	15	3½	5	4	650
4	12	18	4	6	5	768
5	12	21	4	6½	5	768
6	13	22	4	7	5	768
7	14	21	3	7	5	796
8	15	20	2	7	5	780
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2	9	24	2½	4	6	510
3	10	29	3	6	5	580
4	12	33	3½	7	5	690
5	13	33	3½	7	5	730
6	14	33	3½	7	5	740
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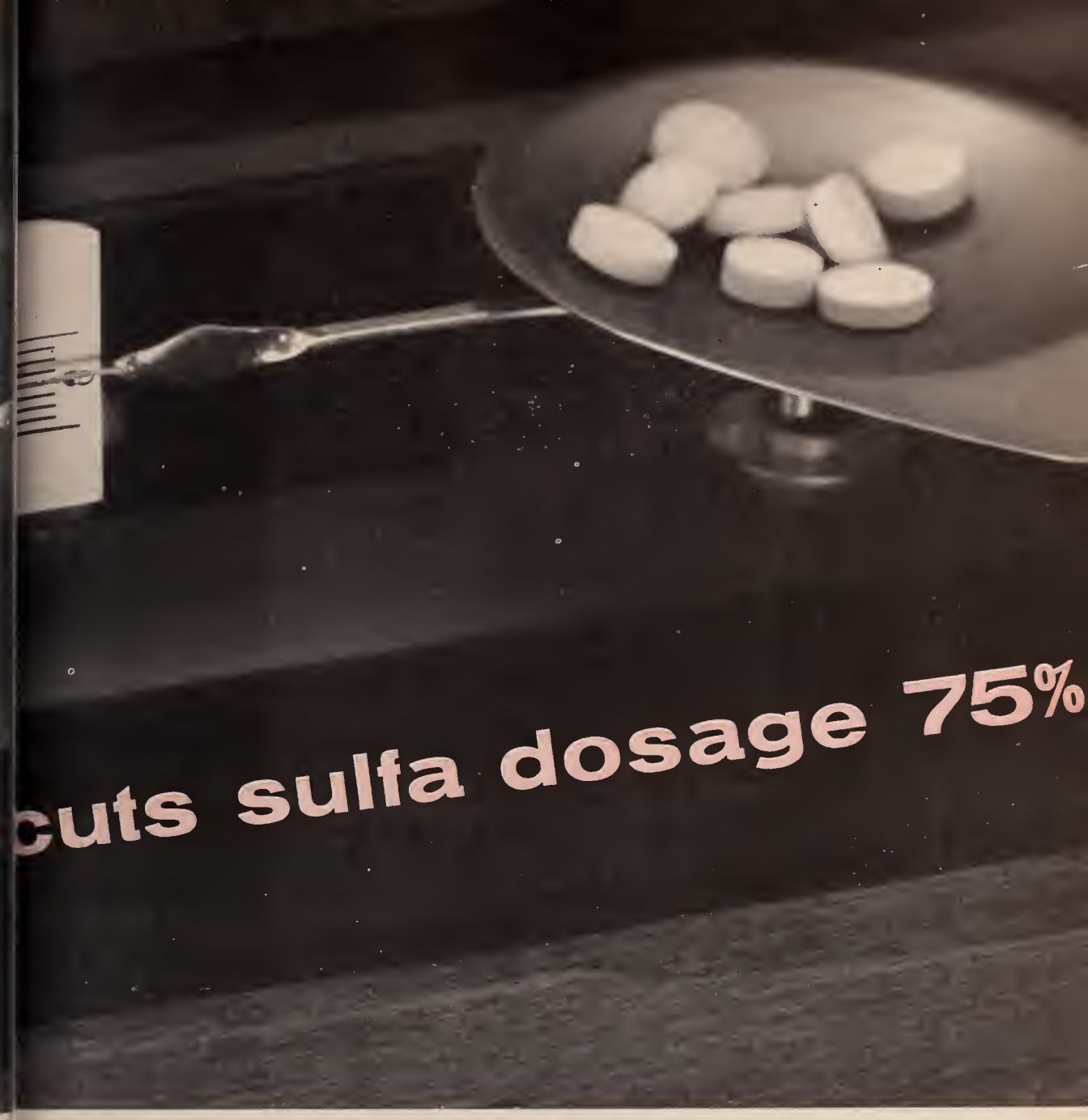
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1. Boger, W. P.; Strickland, C. S. and Gylfe, J. M.: Antibiot. Med. & Clin. Ther. 3:378 (Nov.) 1956.

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---

1. Jackson, P. L.: Iron Deficiency Anemia in Infants, Editorial. J.A.M.A. *160*:976 (Mar. 17) 1956.

2. Martin, E. A.: Roberts' Nutrition Work with Children. Chicago, The University of Chicago Press, 1954. p. 211.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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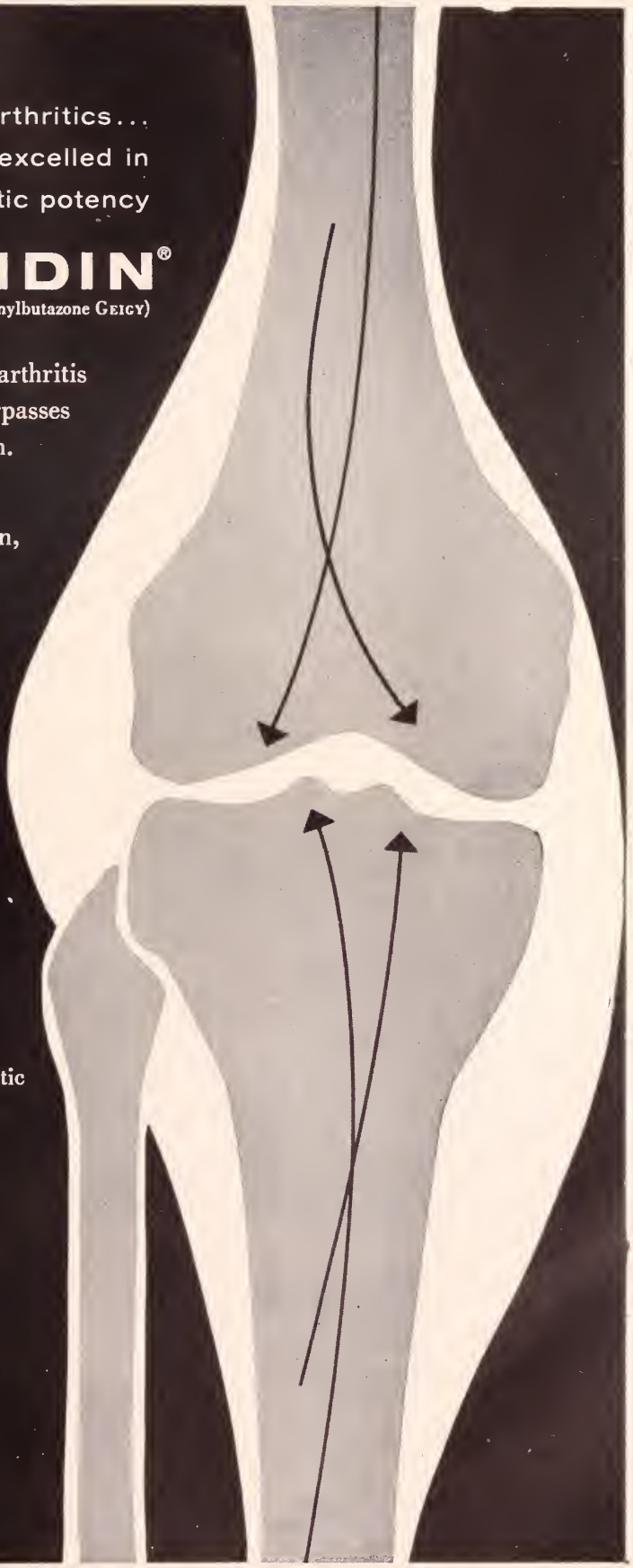
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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Radiation and Self-Discipline

The National Research Council recently issued a warning about the genetic potentialities of radiation. Fear was expressed that future generations might be harmed by the effect on the gonads of x-rays and other types of radiation. Out of this fear came the suggestion that we should "reduce medical use of x-rays as much as possible." No possible personal damage is as frightening to people as the thought of harm to the gonads. For here are wrapped up both sources of deep personal pleasure as well as hopes of all future generations.

The Council's report fails to make clear the distinction between the medically necessary x-ray exposure of sick people and the unnecessary exposure of healthy workers in radiology and roentgenology. The net effect of this frightening report may be to scare people away from necessary diagnostic and therapeutic x-ray exposure. No one favors the indiscriminate use of x-rays. But there are times when the procedure is a medical necessity. Timidity may lead to inefficient diagnostic technics and treatment that is tragically too little or too late.

The unsophisticated reader does not realize that the only ray that can affect fertility is radiation to the gonads. A skull x-ray might be needed to determine if a parietal fracture is depressed enough to require trephining. Only a negligible amount of the radiation here would reach the gonads. Similarly, dental x-rays can be tremendously helpful. Radiation to the reproductive organs from an occasional tooth x-ray is trifling.

There is a real warning, a real challenge and a real lesson in the Council's report. The lesson is that radiation is a potentially mischievous weapon which cannot be placed in unskilled hands. The challenge is to get as much information as possible from the fewest roentgens of exposure—a task for thoroughly trained radiologists. The American College of Radiology says that about 125,000 people today are using x-rays as part of their work. They estimate that only 4000 of these have had the comprehensive and special training of radiologists. This suggests that the use of x-rays has to be policed, and that inadequately trained operators—whether physicians, dentists or technicians—should not be encouraged to venture beyond their depth far out into hazards which, to them, are quite uncharted.

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X-rays have always had this curious "kill or cure" ambivalence. X-rays have always been both a traumatizing agent and a healing force. X-rays can be the wild horses of medicine. These horses need skilled riders. Amateurs can be thrown for a loss.

Syphilis is Still Here

For the first time since 1948, the syphilis rate has increased. In 1948, state health departments reported 338,000 total cases. The incidence then rapidly fell, reaching a low of 122,000 in 1955. But in 1956 the number was up to 126,000—a slight, but unmistakable rise. There has been no corresponding upswing in gonorrhea.* The increment in syphilis is particularly noticeable among teen agers and in transient, mobile groups of people. Even the island paradise of Hawaii has reported an "outbreak of syphilis in an area which had been free of VD for years." One of the therapeutic problems has been the indigent patient who cannot afford private care and who has difficulty finding a publicly operated facility. This has been due to a shortage of VD-trained physicians willing to work in public health clinics, or to inadequate public laboratory facilities, or to poor spacing of clinics. New Jersey is fairly well off in this respect, but vast gaps in public facilities are reported in many other states. As one reporter put it: "It is often difficult for the health officer to bring the patient and the penicillin together."

Some physicians are reluctant to enter into a public document the record of the woes of a private patient. When interest in the disease was at fever pitch, practitioners were constantly stimulated to report every case. Now that interest in syphilis has waned, much of the momentum is lost, and some doctors are not as conscientious as they used to be in reporting. If, as seems probable, under-reporting is commoner now than it was a decade ago, the rise in the syphilis rate is even greater.

Probably the major factor in the rise of the syphilis rate, however, is complacency: the feeling that what was once a scourge has now, thanks to new treatment, been reduced to the level of a minor ailment. Indeed, many of the physicians whose medical education was entirely post-war, have seen so little syphilis that they scarcely think of it in differential diagnosis. Until recently the decline in morbidity was gratifying. But it takes eternal vigilance to keep it that way.

The Growth of the Blues

Ever since the birth of the "Blues," the big news has been their astounding rate of growth. Blue Cross and Blue Shield have hit the jackpot in public acceptance, the former now well past the 50 million mark. The latter will reach 40 million by the end of 1957.

Occasionally one hears the suggestion that Blue Shield attempt to "stabilize" its enrollment, and relax its efforts to cover an ever larger cross section of the population. But the demand for prepaid medical care is now almost universal; and those who have it are asking for broader coverage and better contracts.

Not only does Blue Shield's momentum of growth permit no turning back, but it has grown so big that the public interest in Blue Shield has made it a major item in America's program for social progress. The continued growth of Blue Shield is essential to the best interests of both physicians and the people.

Why essential? One reason is that Blue Shield is a major factor in medicine's econ-

*Except among teen-agers—see pp. 351.

omy. Whereas installment buying creates a debt and mortgages the future, medical prepayment creates a credit for the patient, and protects his future.

Again, Blue Shield's growth safeguards its actuarial base of operations. As risks are spread ever more widely, the community and the doctor gain a surer protection against fluctuations affecting the subscription rates or payments to physicians.

A third benefit of Blue Shield growth is the opportunity to reduce operating costs per person enrolled. This helps the plan to broaden its services or to raise its payments to doctors —or both. Also, the greater the number of his patients covered by prepayment, the fewer for whom the doctor has a collection problem, and the lighter his load of free or part-pay work.

Medicine's most significant benefit from the growth of Blue Shield is the dominant influence of the medically guided Blue Shield Plans on the shape and destiny of the voluntary health insurance movement as a whole. Were it not for Blue Shield, the medical profession would have no effective control over the basic economy of private practice.

Blue Shield is big because it has a big job to do for the doctor and his patient. But the size of Blue Shield is only a reflection of the vision and boldness that the American doctor has brought to bear on this job.

Headless Drivers and Heedless Horsepower

Here's one disease we doctors can't do much about. Coded as "HH," it has the American people in its grip and no miracle drug is in sight to diminish its incidence. HH is heedless horsepower, the chronic disease of the Age of the Automobile. Its symptoms include the heavy foot on the accelerator; the eye fixed on the climbing speedometer; the hand on the horn; the mind idling while the car is in high.

In its 23rd annual highway safety publication, *Heedless Horsepower*, The Travelers Insurance Companies of Hartford, point to the fact that 40,000 Americans were killed and 2,368,000 injured in 1956 on U.S. highways. That's an increase of six per cent in fatalities and nearly ten per cent in injuries over the 1955 toll.

Heedless horsepower is a contagious disease. It can be spread by an irresponsible word, an inflated claim, a careless example. Horsepower, in the hands of the heedless, is the fundamental cause of our ever-mounting pile of gravestones.

Engineers feature safety equipment in the new cars. Lives have been saved by safety glass, seat belts, padded instrument panels and all-steel bodies. But these safety devices can be nullified by any combination of speed plus carelessness, thoughtlessness or lack of judgment by the driver behind the wheel.

The driver, not the manufacturer, the advertiser or the salesman must bear the greatest blame. Only the driver can control the horsepower and use it safely for his greater ease and convenience. The driver is lectured to, legislated at, prayed for and preached to. He nods sagely, promises readily, and forgets everything but his sense of overwhelming power when he steps on the gas.

Casualty lists on U.S. highways have skyrocketted. Last year all records for heedless haste and needless waste were shamefully broken.

Human error is the biggest single cause of accidents. Figures compiled by The Travelers show that in 96 per cent of the fatal crashes last year, the automobile was in apparently good condition. Clear, dry weather prevailed in more than 85 per cent of these instances!

If this year's record is equal to that of 1956, one in 70 Americans will be a statistic . . . a pain wracked survivor, or a name in the obituary column.

Maybe another lane is needed alongside of each motor vehicle inspection station. A lane where they examine the drivers' heads.

MAURICE BEAR GORDON, M.D.

Ventnor

David Allman, The Physician

In any organization, a member must possess the traditional leadership qualities if he is going to reach the top. In medical societies, however, there is an added qualification. He must also be a good doctor. If he cannot earn the professional respect of his brethren, his organizational leadership skills will be in vain. A good example of this combination of leadership talent plus medical competency is here given.

DAVID B. ALLMAN is now the President of the American Medical Association. Much has been written about him as a public spirited citizen. We in New Jersey, know of his work as a Trustee of both our own Society and of the A.M.A. But not enough of us know about Dr. Allman, the *physician*.

I served on Dr. Allman's surgical service at the Atlantic City Hospital in 1940. During the ensuing years of my general practice in this area, I had the opportunity of seeing Dr. Allman in action as surgical consultant.

As a surgeon, Dr. Allman was a man of abundant common sense, few words and much action. He had the knack of separating the wheat from the chaff and getting the salient features of the patient's history in minutes. In problems of difficult differential diagnosis, he took pride in postulating a precise, preliminary diagnosis. All who worked with him marveled at the overwhelming number of times his pre-operative diagnosis was verified by the subsequent surgery.

The word we interns applied to this ability of Dr. Allman was "uncanny." And to render the situation more amazing, Dr. Allman, although he employed all standard diagnostic aids (including roentgenograms and laboratory studies), always rendered his diagnosis privately *before* these studies were consummated. The blood count routinely taken before every one of Dr. Allman's appendectomies was a source of much amusement to the interns. Regardless of the count, Dr. Allman always operated if he had made a provisional clinical diagnosis of appendicitis. On this particular matter, with regard to my patients both during my service as an intern and my years as a practitioner, his batting average was actually 100 per cent and the pathologic report backed up his pre-operative appraisal in every case.

Dr. Allman is one of those few talented and inspired individuals who is a "born surgeon." This term has been applied to many great doctors, but it could not fit anyone better than Dr. Allman. When he operated, every case looked simple. He had the seemingly effortless ability of modifying each surgical procedure to fit the individual patient. The operating time was minimum; the surgical trauma was minimum; and the results were far and away above average. The charts in the record room at the Atlantic City Hospital give mute evidence of these facts. Every intern, resident and assistant who has ever worked with Dr. Allman avidly proclaims their veracity.

He was an unpretentious surgical chief, but all who worked with him knew that he would brook no incompetence. He sized up his fellow man with perspicacity and his hand-picked surgical assistants all developed into first-class surgeons. All of Dr. Allman's assistants knew that he would grant them full operating privileges as soon as their skill passed his rigid specifications. No long term of apprenticeship was demanded or accepted. This is one of many reasons why so many fine surgeons in the Atlantic City area owe so much to Dr. Allman's unselfish preceptorship.

DR. ALLMAN'S "grand rounds" were the grandest grand rounds ever held at the Atlantic City Hospital. Every intern and staff member who could make it was there. And they all came of their own free will for the sheer pleasure of seeing a master at work. No one ever made the "grand rounds" without being handsomely rewarded for his time by absorbing choice morsels from Dr. Allman's seemingly endless professional larder. I believe that no one will contest the statement that Dr. Allman was most beloved by the interns of all staff men in the history of the Atlantic City Hospital.

And did Dr. Allman understand the patients? He certainly did. When they were intelligent, he explained to them the precise nature of the contemplated surgery and his assurance was so contagious that they went up to the operating room placid and unafraid. To the less sophisticated, who wanted little logic but a fancy name, Dr. Allman, all the time keeping a poker-face, would let out a long grunt with an *itis* at the end, following which he would turn on his heels and march out of the room at the head of his entourage, leaving the patient very satisfied with himself and the interns red in the face from suppressed laughter.

I recall only one of my patients on whom Dr. Allman refused to operate. Let us call her Mrs. "X." I had treated her for years, but knew her not one iota as well as Dr. Allman did after three minutes in his examining room. The diagnosis was urethral caruncle and Dr. Allman informed me that anyone who would touch this "belly-acher" with a scalpel would rue the day for the rest of his life. She went to a famous medical center for the surgery. When I last heard, she had haunted the poor surgeon who had performed the operation for at least ten years. How Dr. Allman prognosticated this sequence of events I shall never know!

Dr. Allman's complete lack of braggadocio was further enhanced by his kindness and generosity toward his fellow practitioners. Once I was doing a paracentesis for ascites in an advanced metastasized malignancy case. Feces dripped out of my cannula. I phoned Dr. Allman at once, expecting to be justly chastised for making such an error. When I explained the situation to the good surgeon, he candidly replied: "The same thing has happened to me a couple of times, Dr. Gordon. The patient will probably linger on to perish from her malignancy. Her numerous adhesions will wall off the perforated gut." This patient never even suffered an elevation of temperature. She lived to die of terminal cachexia six months later.

AND one last word must be expressed about Dr. Allman's charity in his *private practice* (as distinguished from his ward work). As Dr. Allman never discussed his many personal charities with anyone, the following incident in my practice must suffice to elucidate this matter: a poor fireman had three children who were constantly ailing from persistent tonsillitis and recurrent quinsy. Dr. Allman performed three splendid tonsillectomies and the father of the children eventually received a bill for $25. The fireman, amazed at the minuteness of the fee, called Dr. Allman to see if there hadn't been some mistake. The good doctor's reply was short: "No mistake!"

These anecdotes are of a personal nature, but perhaps they will give A.M.A. members a better insight into what kind of a *physician* their president is.

6917 Atlantic Avenue

Joseph M. Stein, M.D.

Robert M. Breckenridge, M.D.

Elmer L. Grimes, M.D.

Camden

Adenomyoma of the Stomach*

A Case Report

Is there such a lesion as an adenomyoma of the stomach? Many pathologists and gastro-enterologists label this as a variant of aberrant pancreas. The Lady of Lourdes group here present a case suggesting that adenomyoma may be a recognizable clinical entity.

Adenomyoma of the stomach has been presented as a clinical entity.[1,2] Several features in patients with symptoms support this claim: the described tumors are at or within 4 centimeters of the pylorus; they produce a characteristic pain-complex and have an unusual microscopic picture different from that of pure aberrant pancreas. The symptoms exist from one to ten years and are often of the "hunger variety" that may be relieved by drinking milk. Very striking is the intermittency of the pain in the right upper quadrant or epigastrium. Six to eight weeks may intervene between attacks. Each attack may last seven to ten days. Nausea is frequent but vomiting is uncommon.

Microscopic sections of the neoplasm removed from patients with symptoms practically all contain undifferentiated ducts, Brunner's glands, pancreatic acini and bundles of smooth muscle.

Adenomyoma of the stomach may simply constitute a variant of heterotopic pancreas. Factors in favor of this thesis are: the assertion that only 20 per cent of the patients with aberrant pancreas are symptomatic; the inadvertent encountering of symptomless adenomyomas at autopsy and the allegation that the general clinical behavior of adenomyoma is similar to that of aberrant pancreas. Since adequate gastro-enterologic history may be lacking in these instances, these claims may not be valid.

The following case appears to meet the features suggested as characteristic for adenomyoma of the stomach.

A 50-year old woman was admitted to Our Lady of Lourdes Hospital complaining of right upper quadrant pain of ten years' duration. It was a constant, gnawing pain, relieved for about an hour after drinking milk. Frequent transient waves of nausea were noted but no vomiting. The pain did not radiate. Occasionally it would be felt more in the right epigastrium than in the right upper quadrant. It was never severe enough to awaken her at night. Following eight to ten days of persistent, boring pain, four to six weeks might pass before another attack ensued. Physical examination was negative except for mild tenderness to deep palpation in the right upper quadrant. X-ray of the stomach revealed a small filling defect of the greater curvature as shown in figure 1.

Exploratory laparotomy was done under spinal anesthesia through an upper mid-line incision. On the anterior aspect of the pylorus a 1 by 1 centi-

*From Our Lady of Lourdes Hospital, Camden, New Jersey.

1. Woolsey, J. H. and Millzner, R. J.: Archives of Surgery, 16:583 (Feb. 1928).

2. Grossman, L. W. and Kidder, J. H.: American Journal of Surgery, 54:395 (Dec. 1941).

meter greyish thickening was encountered. It was suggestive of an old ulcer cicatrix. Gastrotomy revealed a granular appearance of the overlying mucosa but no ulceration. The lesion now felt like an ovoid tumor. We thought it was benign. The pylorus and lower antrum were resected and gastro-intestinal continuity was restored by the Billroth I technic. Since the operation, she has had no symptoms.

Figure 2 shows the mass on the anterior aspect of the pylorus. This well-circumscribed nodule showed no distinct mucosal ulceration. The cut surface was yellow-white, bulging, lobulated and homogeneous. The microscopic features of this tumor are seen in figure 3. It consisted of a mixture of undifferentiated ducts, smooth muscle bundles and pancreatic acini. Large irregular muscle bundles adjacent to distorted, dilated ducts lined with columnar epithelium were the prominent feature. Only a rare lobulated mass of pancreatic parenchyma was found. Those present were adjacent to the overlying Brunner's glands. See figure 4.



Figure 1.

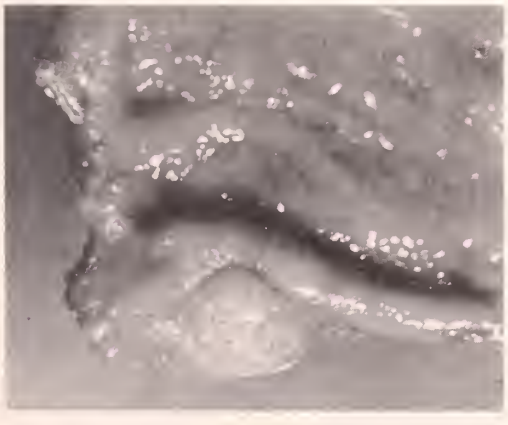


Figure 2.

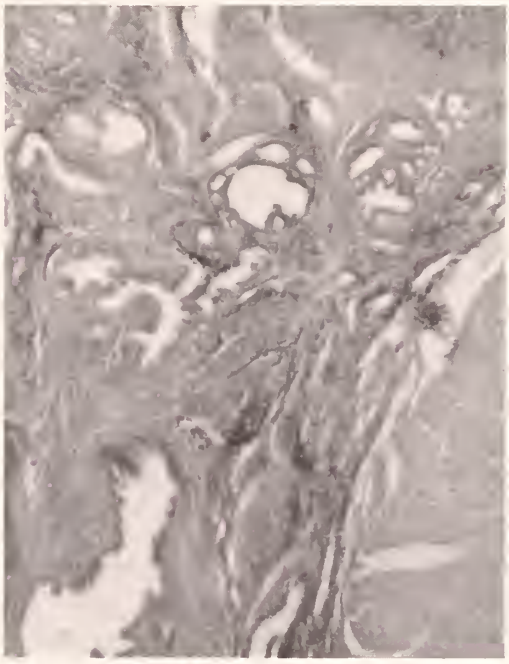


Figure 3.

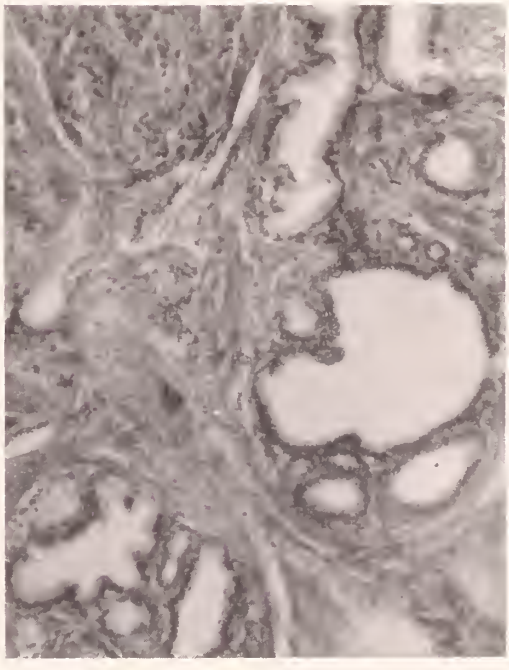


Figure 4.

Figure 5 defines more clearly the inflammatory reaction around one of the ducts. These cells are mainly lymphocytes and a few eosinophiles. The lining epithelium is identical to that which lines the ducts of the pancreas.

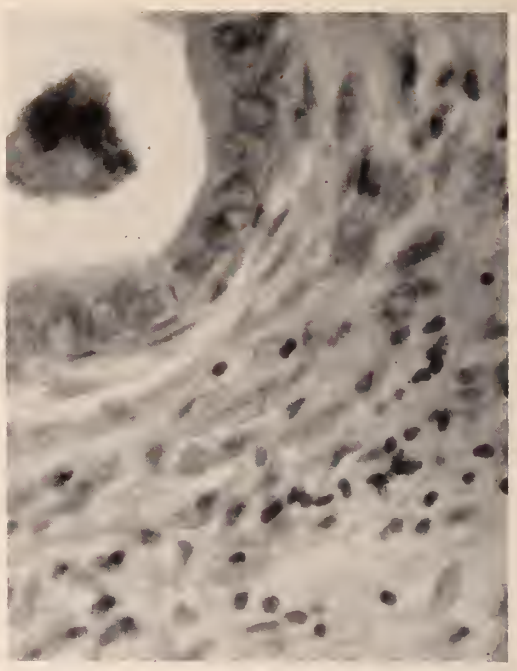


Figure 5.

Adenomyomas have been[1] described as one to two centimeter round or elliptical tumors[2] occurring in the distal four centimeters of the stomach. The overlying mucosa is frequently intact and glides smoothly over the neoplasm.

Occasionally the mass is ulcerated or associated with a diverticulum. The cut surface typically reveals a bulging, firm, yellow-grey tumor that may involve any or all coats. Occasionally small cystic spaces containing mucus may be seen with the naked eye. Rarely, the cystic change actually predominates. Microscopically, adenomyomas contain epithelium of Brunner's gland, pancreas or an undifferentiated type. The undifferentiated glands are more common and give the lesion a neoplastic appearance. The adenomyomas, as the name implies, also contain smooth muscle. This is in the form of hyperplastic bundles arranged haphazardly around and between the glands. It may be the predominant element of the tumor. This is the reason some of these adenomyomas have been mistakenly diagnosed as leiomyomas when the glandular elements were overlooked or mistaken for degenerative changes in a leiomyoma.

In the clinical differential diagnosis one cannot distinguish this from the aberrant pancreas which is also an intramural lesion. In most instances, however, it can be differentiated from two other intramural neoplasms: neurofibroma and leiomyoma. These tumors frequently are greater in diameter and are found either in the fundus or body rather than in the pylorus or antrum. Eccentric craters are frequently noted on the surface of them.

Polyps are commonly multiple, more often larger in diameter than adenomyomas, have a tendency to ulcerate and bleed and may be pedunculated or lobulated. Lymphomas, syphilis and tuberculosis all tend to involve a major portion of the stomach and do not commonly cause confusion in diagnosis. Carcinoma cannot be ruled out.

SUMMARY

A CASE of adenomyoma of the stomach is reported. Whether this is a distinct entity or remains as a variant of aberrant pancreas is discussed. Since the intermittency of the patients' complaints are often suggestive of a functional disorder and since the x-ray findings are frequently insignificant, adenomyoma of the stomach is probably more common than generally realized. Further reporting of these cases is suggested.

414 Cooper Street (Dr. Grimes)

Harold E. Lippman, M.D.

Newark

The Enigma of Development, Disease, and Death

Here is an intellectual challenge to the doctor. No easy reading, this essay will stimulate your thinking about the enigma of death, development and disease. Will the simple Newtonian cause-and-effect logic suffice for the complex world of today? Read on and see!

On the death certificate the inadequacies of modern medical science and of medical scientists stare us in the face. Here a counterpart may be found for every unsolved dilemma of the basic biologic sciences. When the clinician lists one cause of death, and the pathologist suggests another, it is possible that either (or both) is ignoring the fundamental unity of structure and function, pathology and physiology. It is likewise possible that the differences in opinions may be reflecting the undecided issue between the vitalists and the mechanists.

The apparent immensity of the problems inherent in the very phrase "Enigma of Death" must not be allowed to stifle thought on the basic issues. Treolar [1] states that "It is a false proposition that each death is a response to a single cause." We must state the general falsity of single "causation" in disease. Yet how much closer to reality does a multiple listing of "causes" of death or disease bring us? We may list the causes of death or disease starting with myocardial infarction and running through a score of conditions ending with ingrown toe nail or epidermo-phytoses, and then with justification we may ask "Is this all?" and we must answer "No! This is not all!"

In everything that *is*, there is a record of *what has been* and a portent of *what will be!* Ontology cannot be understood without ontogeny! Treolar [1] emphasized ". . . the countless number of antecedents throughout past time (including all ancestors) that led to those circumstances." In this sense the very origin of life enters into the questions of growth, disease and death. Life, growth, disease are all developmental processes the courses of which are influenced by the residua of individual experiences [2] and by experiences of the race, species, and ancestral forms of life as handed down in the course of evolution.[3] The effect of the immediate circumstances, the environmental impact on the individual living unity, cannot be evaluated without regard to the individual and racial history. This applies to both internal and external factors — to trauma or to an internal disease process. The "environmental impact" may consist of a multiplicity of diseases each of which is itself a developmental process and each of which has an effect upon and is affected by the others.

1. Treolar, Alan E.: Journal of the American Medical Association, 162:1377 (Dec. 1956).
2. Lewes, George Henry: *Problems of Life and Mind*. London 1874, Trubner.
3. Orr, Henry B.: *Development and Heredity*. New York 1893, Macmillan.

Disease may be used to fight disease. Tendencies of certain diseases and even blood groups to occur together are well known. On the other hand, a particular medication may have opposite effects in different individuals. How can these paradoxes be explained? The problems of the paradoxes in disease and treatment are inseparable from the problem of "being" and "becoming."

As a special instance of this general problem, let us restrict our attention to the development of disease, since this is germane to the question of "causes of death" as well as to our every day activities as physicians. In this process we may establish three phases; the onset or initial phase; the course or the development *per se*; and, finally, the termination in recovery or death. At the onset, something new impinges on the old established living process. The nature of the living process as well as the nature of the new element will "determine" the course of the new process. At the onset of an infectious disease the bacterium does not cause the disease. The interaction of the bacterial life processes with those of the host "determines" the outcome — whether or not disease will occur. Likewise, when a normal cell gives rise to malignant progeny it is the interaction of the living malignant cells (or better—malignant process) with the entire organism that "determines" the outcome. It is only from this point of view that the numerous discussions about *carcinoma-in situ*, and the like, can take on meaning.

The initiation of a process as well as the termination have special significance. Yet the same sudden changes which strike us so forcibly at the beginning and the end are also present in the middle development. It is the nature of life that small changes are not noticed. The small and unnoticed change is the same fundamentally as the large and abrupt. Neither can be explained by "cause and effect" logic. Rather must we seek for the "cause" of each result in the antecedent complexity. It is the whole process which from within itself gives rise to the resultant "state." The "state" itself is a convenient fiction that changes before we can name it.

Life, growth and disease are developmental processes, and as such they are beyond the simple realm of Newtonian "statics" and the simple cause and effect logic which this entails. Since death results from processes in the living, the analysis of "cause of death" must transcend Newtonian logic or be deficient. Physics was forced to do this and medicine must also.

No process, no change, no development, no growth can be explained by cause and effect logic. As Bertrand Russell [4] has pointed out ". . . if there are causes at all, they must be separated by a finite interval of time from their effects, and thus cause their effects after they have ceased to exist." Russell [4] also says: "The reason the old 'law of causality' has so long continued to pervade the books of philosophers is simply that the idea of a function is unfamiliar to most of them, and therefore they seek an unduly simplified statement." But function is process.

The great American biologist, Henry B. Orr,[3] recognized the inadequacy of cause and effect logic. In the following passage he expresses his view of the causation of the constant changes in development:

"As the development of an organism is a process of constant change, there must arise at every moment a new relation of the forces which cause the change. At each moment the action of the various forces causes the developing organism to change. This change results in a new arrangement of the parts of the organism, *i.e.* a new combination of its internal forces. Now, whether the external forces remain the same, or whether they change, we have in either case a new combination of the whole complex arrangement of forces which act to produce development. This new combination we must regard as the cause of the immediately ensuing step in development. Thus every step in development is the result of a particular combination of forces acting at the proper moment. These combinations of forces follow each other in fixed and regular sequence, and blend one with the other. As the sequence is generally the same for all organisms of a species, so the organisms resemble each other. Where the sequence for any individual differs from the sequence for the rest of the species, that individual will differ in growth from the rest of the species, provided always that the dif-

4. Russell, Bertrand: *Readings in the Philosophy of Science*. New York 1953. Appleton-Century-Crofts

ference be not so great as to destroy the life of the individual."

The constellation of diseases that terminates in death is a process of interacting forces that may be traced backward to the origin of life. Any event along this course must be considered to be causative only in so far as it is part of the total pattern of forces. It becomes one cause among many during any particular instant. The total process is the integration of instantive changes. Process has its own laws, which have been commented on even by the ancient Greeks. On an excellent philosophical basis as well as a huge knowledge of biology and neurology, George Henry Lewes wrote his monumental *Problems of Life and Mind*.[2] The processal method as modified and employed by Lewes is to my mind the greatest tool for advance in the medical sciences! It is the key to the solution of the "vitalism-mechanism" issue; the key to the puzzles of the "psyche" and the "soma." Lewes illuminated the weaknesses of the Cartesean dichotomy of mind and body and postulated the unity of the psychological and the physiological processes.[2] A genius far beyond the ken of his time, his works are a treasure both for the postulation and the solution of the problems of medicine. The vast stores of knowledge in the biologic sciences of embryology, neuroanatomy, neurophysiology, physiology and biochemistry, as yet unsystematized, cry out for the lucidity of the Lewesian approach.

SUMMARY

THE enigma of "cause" of death can best be solved hand in hand with the enigmas of the origin of life, growth, development, disease, and ageing. From the very generally admitted position that the "causation" of death (like the causation of disease) is often multiple, we must advance to the position of challenging the dominance of simple Newtonian "cause and effect" logic in medicine and the biologic sciences—a challenge which was long ago made and is today generally accepted in the field of physics. It is argued that processal logic when applied to the systematization of the voluminous data available today, will lead to rapid and profound advances in the medical sciences.

68 Elizabeth Avenue

They Never Returned

In 1956, more than fifteen thousand individuals didn't return home after the pleasures of the weekend. According to figures recently published by The Travelers Insurance Companies of Hartford, 15,730 American were killed in weekend traffic accidents.

Of last year's traffic fatalities, more than one-fifth occurred on Saturday.

Every highway has its Saturday share of that portion of America bound and determined to arrive at its weekend destination in time for dinner, even if the trip's last sixty miles must be covered in an hour flat. Too frequently, the strain and fatigue of distance driving are ignored in anticipation of ample relaxation at the journey's end.

Then, too, our highways continue to be filled with those drivers whose idea of relaxation is an extra drink or two "for the road." The weekends of 1955 saw *more persons killed and injured on our highways than ever before*. It wasn't the fault of the road systems; it wasn't the fault of safety education campaigns. It was the fault of pleasure-bent individuals striving to go too far, too fast, for a weekend's enjoyment.

How to reduce this record total of killed and injured? What is desperately required is the immediate, unceasing cooperation of every American in possession of a driver's license.

Peter H. Shershin, M.D.

Upper Saddle River

V. Terrell Davis, M.D.

Trenton

Toxicity of Carbarsone as an Anti-Amebic†

Widely recommended as a harmless amebicide, carbarsone was actually found too toxic for continued use in about half of the subjects to whom it was administered.

Carbarsone, an organic pentavalent arsenical, 4-ureido-1-phenylarsonic acid, has been in use as an amebicide[1] since 1931. Its continued popularity, in part, has been its relative lack of toxicity, although gastro-intestinal complaints, dermatitis, and edema have been the more common innocuous reactions mentioned.[1,2,9] Rarely, exfoliative dermatitis, encephalitis, and liver necrosis were encountered. Various investigators reported little or no toxicity. Recently, 285 presumably normal adults were given carbarsone to eradicate an amebic carrier state known to exist at the North Jersey Training School for Girls in Totowa. The data are published because of the high incidence of untoward reactions in this group.

Our series consisted of 285 asymptomatic adults. Nearly all were females, their ages ranging from the second through the sixth decades. Each received 250 milligram tablets of carbarsone three times daily for one week. All information regarding toxicity was deliberately withheld from those concerned.

†This work is from the New Jersey Department of Institutions and Agencies, and more specifically from its North Jersey Training School at Totowa. We are indebted to Dr. Harold W. Brown, professor of Parasitology at Columbia University, for many helpful suggestions. Charles F. Chamberlin, Sanitation Officer and Dr. D. J. Buttimore, Director of the Training School also helped us, and we are grateful for this assistance. P.H.S.

Symptom	Total	Per Cent
Diarrhea	135	76
Abdominal distension	112	63
Abdominal pain	66	37
Nausea	49	27
Headache	47	26
Anorexia	38	21
Anal pruritis	37	21
Dizziness	35	20
Dermatitis	23	13

Two weeks after the course of therapy had been completed, we sent questionnaires to the 285 subjects. Of these, 179 returned the forms. Multiple, rather than single symptoms, prevailed.

Gastro-intestinal symptoms predominated. Diarrhea was present in 76 per cent, while 63 per cent had abdominal distension. Abdominal pain, nausea, and anorexia involved 37 per cent, 27 per cent, and 21 per cent respectively. Only one subject vomited. Twenty-three (13 per cent) noted skin reactions: diffuse, pruritic, macular lesions associated with edema, primarily facial in location. Malaise (manifested chiefly by headache and dizziness) occurred in 23 per cent of the subjects. Of the total group, only 80 (or 45 per cent) were able to complete the full course of therapy.

SUMMARY

Of 179 normal adults given 250 milligram tablets of carbarsone three times daily, only 80 (or 45 per cent) were able to tolerate the amebicide for one week. The remaining 55 per cent discontinued therapy because of side effects.

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Cardiac Tamponade

Farringer and Carr (page 437 of April 1955 Annals of Surgery) conclude that cardiac tamponade should be treated with primary aspiration of the pericardium and supportive intravenous therapy. Open thoracotomy should be reserved for those showing a continued tendency to relapse, with falling blood pressure and other evidence of recurring intrapericardial bleeding. Even if cardiorrhaphy is required, there is better chance of survival if the blood pressure has been temporarily restored to normal. In the series reported there was no significant difference in mortality between the group treated by open operation and those treated by aspiration. These writers see no reason to operate upon patients who respond to aspiration alone. In the series of 30 patients, there was a mortality of 36 per cent. However, in 6 the penetrating wound of the heart was completely overlooked. In 23 whose condition was promptly recognized and treated, 19 survived, bringing the mortality rate for this group down to 17 per cent. Seven of the 11 deaths were due directly to the failure to recognize the tamponade and treat it promptly.

A penetrating wound may force the blood into the pericardial sac, creating a pressure which interferes with blood flow from the vena cava and pulmonary veins to the heart. Venous pressure consequently increases in both systemic and pulmonic circulations. Stroke volume of the heart is reduced, with reduction in the minute output of the heart and decrease of flow through the coronary vessels and to the brain. Although the tamponade encourages clotting in the wound, decreased cardiac output and venous congestion demand relief by the time definitive therapy is available.

All penetrating wounds of the chest should inspire a high index of suspicion. Classic signs of cardiac tamponade are markedly narrow pulse pressure even before blood pressure falls to shock levels, a dusky cyanosis, distant heart sounds and distended neck veins.

J. Charles Breme, M.D.

Laurel Springs

A Year of Cardiac Catheterization in a 300-Bed Hospital

The moderate sized hospital—the 200 to 500 bed institution—is sometimes too modest to attempt some of the more complex technical procedures. As demonstrated here, a 300-bed hospital—in this case the West Jersey at Camden—can develop and operate an efficient cardiac catheterization technic.

Cardiac catheterization has become a necessary procedure in larger hospitals and in other institutions where cardiac surgery is performed. The technic to date, approaches more closely the true physiology of the heart than any other procedure yet devised — despite its obvious limitations.

It is my aim, in this paper to suggest that right, left or combined heart catheterization need not be restricted to hospitals directly affiliated with teaching institutions or to hospitals of great size; and that it may, in fact, become a major link in the diagnosis and treatment of heart disease in smaller hospitals.

Staff acceptance and approval is a necessary prerequisite to the establishment of such a subsection. And after one year of operation in a three-hundred bed hospital,* we believe our laboratory has found general acceptance of the staff. It is hoped that from our experiences with the ordinary run of cases plus some unusual ones, there might be encouragement for others to establish catheterization teams in smaller hospitals. The series here reported consists of the first fifty-four cases studied in our first year of operation, regardless of age, sex, type of defect or degree of severity.

*West Jersey Hospital at Camden, N. J.

METHODS AND MATERIAL

Fluoroscopy was done with a Westinghouse 500 MA fluoro-radiographic unit combined with an image amplifier (Fluorex®) which has very definite advantages and few disadvantages.[1,2]

Pressures were recorded with Statham strain gage pressure transducers P23AA connected to strain gage amplifiers on a Research Recorder® (manufactured by Electronics for Medicine). With Statham P23AA transducers (750 millimeter range) chart deflections of 10 millimeters per millimeter of mercury pressure are "routine." Drift is less than 1 millimeter of mercury per hour. Mean pressures are recorded electrically. In the event of simultaneous pressures, we are fortunate in having two transducers with the same calibration factor.

Cardiac output is determined by the Fick principle,[3] collecting the patient's expired air in a Collins chain compensated gasometer (120 litre capacity) and measuring oxygen tension with a Beckman oxygen analyzer, Model C. The analyzer operates on the simple principle of the magnetic susceptibility of oxygen, it being strongly paramagnetic while other gases, with few exceptions, are diamagnetic.

Oxygen content of blood samples is measured by the manometric Van Slyke blood gas apparatus according to the method of Van Slyke and Neill.[4]

Material for this paper included the first fifty-four cases studied regardless of age, sex, type or severity of lesion or defect. There have been a number of patients operated upon, without previous hemodynamic studies where the diagnosis has been clear cut and pure; as, for instance, mitral stenosis. These are not included in the present series.

Left heart catheterization has been performed very sparingly with the hope that mortality rates and post-catheterization complications could be kept at a minimum. Even though five left heart catheterizations have been combined with our right heart series,[10] experience with the procedure has been minimal and does not warrant comment at this time.

Angiocardiography, left ventriculography and retrograde aortography have been excluded from the present series. The cases here presented include only those with the routine diagnostic work-up plus right heart catheterization.

Each patient, in addition to cardiac catheterization, routinely receives a comprehensive cardiovascular history, physical examination, pertinent blood studies, one or more electrocardiograms with eight chest leads (RV_4 to V_7) and a cardiac radiologic survey. Any additional studies depend upon the individual case studied.

COMMENT

THIS present series included twenty-four males and thirty females with the average age of the former as 20 years and the females, 25 years (table 1). There were 26 cases of congenital heart disease, 25 of acquired heart disease, 2 murmurs of no physiologic significance and one case of essential hypertension in an 8-year old boy (table 2).

Ten-year age increments were used to implement the study. By subdividing each decade into "congenitals" and "acquireds" (table 3), we found two cases of congenital heart disease between the ages of 41 and 50 and one between the ages of 51 and 60. All three were either undiagnosed or had been previously labelled "rheumatic heart disease." There were no cases of acquired heart disease in the first decade of life, although two patients had been suspected of having had initial attacks of rheumatic fever.

Of the 14 children, seven—exactly 50 per cent—had been discharged from a hospital following birth as presumably normal infants. This is a high ratio if consideration is given to the fact that one of the "normal" infants had a transposition and another had a truncus arteriosus. These data are not intended to reflect on the ability or integrity of any physician responsible for the examination of newborn infants. Some types of congenital heart disease simply do not manifest themselves until months or years after birth.[1]

Table 4 lists specific defects only. Twenty-four cases of congenital heart disease are listed in table 2 and 30 specific defects are found in table 4. Several patients had more than one defect. Our one case of dextrocardia is not included in this paper. There is a difference of opinion as to whether isolated dextrocardia is true congenital malformation. Some

TABLE 1. SEX AND AGE INCIDENCE

	Male	Female
Cases	24	30
Age average	19.8	25.2

TABLE 2. CONGENITAL VS. ACQUIRED

	Male	Female	Total
Congenital lesion	15	11	26
Acquired lesion	7	18	25
"Innocent" murmurs	1	1	2
Hypertension	1	0	1
Total	24	30	54

TABLE 3. AGES OF PATIENTS

	0-10	11-20	21-30	31-40	41-50	51-60	Total
Congenital	14	9	0	0	2	1	26
Acquired	0	2	4	8	6	5	25
"Innocent" murmurs	1	1	0	0	0	0	2
Hypertension	1	0	0	0	0	0	1
Total	16	12	4	8	8	6	54

say it is malposition rather than malformation. However, our patient with dextrocardia also had a patent ductus arteriosus, an atrial septal defect and anomalous pulmonary venous drainage. These three malformations are the items listed.

Cardiac catheterization, when combined with other appropriate studies: history, physical examination, electrocardiogram, radiologic survey, angiocardiography, and so on, offers the best means for diagnosing certain types of heart disease, especially congenital ones. It is not infallible, even in the most experienced hands. We were aware of two instances of misdiagnosis. One was a transposition in a one-year old male infant and an atrial septal defect in a twelve-year old boy. Necropsy findings in the former indicated a Tetralogy of Fallot. Attempted atrio-septo-pexy in the latter revealed a ventricular septal defect with tricuspid insufficiency, the leakage of oxygenated blood from the right ventricle regurgitating through the tricuspid valve causing a significant step-up in oxygen content of right atrial blood.

There seemed to be no significant sex difference in this series of congenital cases, with 14 males and 11 females studied. It appeared to be quite different, however, with acquired lesions. Here females predominated over males in the ratio of 2½ to 1. Statistical significance would attach to the much higher incidence of females involved if such a difference were confirmed on a larger series of cases.

Although every patient coming to surgery may not be a candidate for heart catheterization, it is always desirable to have pre- and postoperative physiologic data for comparison, and to rule out any concomitant congenital defect in acquired heart disease.

Several patients, not included in this series, have been operated upon without previous hemodynamic studies. Without listing separate lesions, the acquired cases have been divided into those with a single valve disease and those with multiple valvular involvements. I have subdivided the former into those with single and those with multiple lesions of the same valve(table 5). Those with single valve lesions outnumbered those with multiple valve

TABLE 4. CONGENITAL DEFECTS

Defect	No. Patients
Patent ductus arteriosus	2
Aortic stenosis	4
Atrial septal defect	5
Ventricular septal defect	6
Pulmonic stenosis	3
Truncus arteriosus	1
Tetralogy of Fallot	1
Transposition	1
•Persistent ostium primum	1
Idiopathic dilatation, pulmonary artery	1
Endocardial fibro-elastosis	1
Anomalous pulmonary venous drainage	2
"Innocent" murmur	2

TABLE 5. ACQUIRED LESIONS

Type	No. Patients
(1) Single valve involved	20
(a) Single lesion	11
(b) Multiple lesions	9
(2) Multiple valves involved	5
(3) Total	25

lesions in the ratio of 4 to 1. There is almost equal division between patients with a single lesion and those with multiple lesions involving the same valve. Putting it another way, patients with rheumatic heart disease are more likely to have only one valve affected but are just as likely to have more than one lesion per single valve. These conclusions are drawn from our limited series of cases and cannot necessarily be applied with any degree of finality to a larger series. Our statistics may change as more cases are added to those presented here.

The mitral valve was involved in 63 per cent of the cases of acquired heart disease, with 89½ per cent of mitral valve involvement occurring as either pure mitral stenosis or combined with varying degrees of mitral insufficiency. There were only two cases of pure mitral insufficiency studied. The apparent reason for this is that all patients were brought to our department with the prospect of cardiac surgery in mind. No patient, to date, has been subjected to surgery for mitral insufficiency in annulus plication of the mitral valve.[13] Therefore, as expected, the vast majority of this series involving the mitral valve consisted

of those with pure mitral stenosis or mitral stenosis combined with clinically insignificant degrees of regurgitation.

One-half (30 per cent of those with mitral involvement) had aortic valvular involvement. Only two patients had pure aortic stenosis. Seven had combined aortic stenosis and insufficiency. Surgery for aortic insufficiency is far from satisfactory at this time. As a result of the poor surgical outlook for this type of aortic valve lesion, no patient has been operated at our institution. There are three such cases in which surgery is being contemplated as last ditch salvage efforts until something better comes along.[14]

One patient had both mitral and tricuspid stenosis, the diagnosis of tricuspid stenosis having been made on the basis of a diastolic gradient of 6 millimeters between right ventricular endiastolic and right atrial pressures, plus the presence of giant "A" waves in the right atrial pressure curve during cardiac catheterization.

COMPLICATIONS

RIGHT heart catheterization carries with it a certain amount of morbidity and may even cause fatalities. The incidence of both appears considerably higher in left than in right sided catheterization.[10]

Immediate post-catheterization complications consisted, in the main, of chills and fever occurring from 20 to 30 minutes following the procedure and lasting from 4 to 24 hours. These episodes have occurred in a discouragingly high proportion of patients. An investigation is under way to try to discover and eliminate the cause.

More profound and serious complications have occurred in but very few of those studied and the majority of these were attendant with left heart or combined procedures. An occasional serious complication is to be expected since all of these patients have defective and poor cardiac equipment from the outset (table 6). Perhaps the patient who had a Stokes-Adams seizure should not be included, as the episode occurred immediately following phlebotomy but prior to intubation of the vein with the catheter. A vigorous thump on the anterior chest wall restored sinus rhythm.

TABLE 6.

POST-CATHETERIZATION COMPLICATIONS

Types	No. Patients
Chills and fever	32
Stokes-Adams seizure (ventricular standstill)	1
Peripheral circulatory collapse	3
Transient cyanosis	1
Paroxysmal atrial tachycardia	1
Cerebro-vascular accident	1
Left ventricular failure	1
Depressed state (emotional)	1

Since left and combined catheterizations have not been included in this paper, elimination of these three cases plus the Stokes-Adams seizure brings our corrected serious complications incidence to 0.9 per cent. The overall morbidity on the first 54 cases studied is 17 per cent, exclusive of those who had chills and fever.

A word about some of these other complications is in order here. A seven-month infant with endocardial fibro-elastosis went almost immediately into left ventricular failure but responded nicely to digitalization and was sent home to die.

One patient who had mitral stenosis, aortic stenosis and aortic insufficiency was found to have a spastic paralysis of her left arm and left leg the day following catheterization. Although she has since been operated and is doing well, peripheral embolization apparently occurred either during or immediately following the procedure.

A marked, 24-hour depressive state occurred in a sixteen-year old girl with aortic stenosis and insufficiency in whom we were attempting to eliminate a concomitant congenital defect.

Few patients will stand this procedure without some electrocardiographic abnormalities occurring during manipulation of the catheter.[9] By far, the most frequent arrhythmia we have encountered has been ventricular premature contractions, either isolated or accompanied by short bursts of ventricular tachycardia (table 7). Fortunately most of these

arrhythmias can be terminated by moving the catheter tip from the irritable focus.[2] Scanning of table 7 will show that these arrhythmias have been many and varied.

On two occasions it was found necessary to digitalize patients for control of an episode of paroxysmal atrial tachycardia; one in a twelve-year old girl with dextrocardia, patent ductus arteriosus, atrial septal defect and anomalous pulmonary venous drainage; the other was for the seven-month infant with endocardial fibro-elastosis.

It has been our routine procedure to take an electrocardiogram on patients just prior to catheter intubation and again upon termination of catheterization. Upon reviewing these tracings, it was found that one four-year old boy with an atrial septal defect had a Wenckebach phenomenon, immediately preceding catheterization which reverted to normal sinus rhythm during the procedure only to convert back to Wenckebach conduction upon withdrawal of the catheter. As far as is known he still has this conduction defect.

We have found, on occasion, that close monitoring of the electrocardiogram during manipulation of the catheter may offer a clue as to the approximate position of the catheter tip, especially in passing it through the tricuspid valve. Continuous electrocardiographic monitoring is only one of the many safety precautions employed during catheterization.[2] It has been suggested that all patients coming to catheterization be digitalized prior to the procedure. I do not think this is necessary unless clear cut indications for digitalization are present.[7] The arrthythmias are common, but most of them are transient and of short duration.

Eight of our 54 patients died. However, no evidence has been established that any of these were due, directly or indirectly, to the catheterization. One six-month old infant with a ventricular septal defect died 40 hours postoperatively following successful repair with open heart surgery. Another eight-month infant expired 10 hours post-catheterization. Both infants died of asphyxiation. A fifty-five year-old female, desperately ill with pulmonic stenosis and a ventricular septal defect with a right-to-left shunt, died on the operating table of ventricular fibrillation during attempted pulmonary valvulotomy. Two patients expired suddenly at home from causes unknown. A sixth patient with multivalvular involvement had a sudden cardiac arrest 36 hours following catheterization which responded to heart massage for two hours. He expired from a second arrest two hours later. The seventh, a twelve month infant with transposition, died during an episode of acute pulmonary edema. Our final mortality occurred from an overwhelming subacute bacterial endocarditis 3 months postoperatively. Only three Negroes (2 females) have been studied at this writing. All three had rheumatic heart disease.

TABLE 7.

ELECTROCARDIOGRAPHIC ABNORMALITIES

Arrhythmia	No. Patients
Atrial premature contractions	8
Ventricular premature contractions	34
Paroxysmal atrial tachycardia (short runs)	4
Paroxysmal ventricular tachycardia (short runs)	8
Bundle branch block (transient)	3(a)
Heart block	12
First degree	2
Second degree	3
Complete	2
Wenckebach	1
Sino-atrial	4
Nodal beats (isolated)	9
Nodal rhythm	1
Fusion beats	1

(a) Two were left sided.

SUMMARY

1. The first 54 cases studied by cardiac catheterization at our three hundred bed hospital* have been analyzed statistically. These cases represented a consecutive series. There was no selection by age, sex severity or type of defect or lesion.

2. There has been almost equal division between males and females in our group. The same equal division holds between congenital defects and acquired lesions. There did not

*West Jersey Hospital at Camden, New Jersey.

seem to be any sex preponderance in those congenital cases. In our small series, the ratio of females to males was 2½ to 1 in acquired lesions. Twenty-five cases are not enough to invest this datum with statistical significance. If this ratio holds in a much larger series, it could be significant.

3. The majority of patients with congenital heart disease fell into the first two decades of life. Only 7½ per cent were in the 21 to 30 age group. Three patients had progressed past the age of forty before their congenital cardiac defects were known specifically; two of the three having done quite well at the time of study.

4. Congenital defects showed a wide range of variability. Most occurred as isolated malformations in the form of septal defects — either interatrial or interventricular.[3] Single valve lesions predominated in a ratio of 4 to 1 in our acquired series with multiple lesions occurring on the same valve with equal frequency as those with a single lesion on a single valve.

5. Post-catheterization complications of a relatively minor nature occurred with alarming frequency. More serious complications have not been frequent. Electrocardiographic abnormalities have run the gamut of arrhythmias and transient conduction defects with ventricular premature contractions occurring most frequently either as isolated beats or as short runs of tachycardia. Fortunately, changing the position of the catheter terminates the arrhythmia in most instances.

6. No deaths were attributable directly to heart catheterization. Eight patients expired from one cause or another at varying intervals of time following the procedure.

CONCLUSIONS

It is perfectly proper and within the realm of good practice to develop (within the cardiology department of a small or moderate sized hospital) a subsection capable of studying cardiac physiology. Our attention has been directed strictly to diagnosis. It is becoming more obvious even to the most agnostic that cardiac catheterization is an important aid in the diagnosis of certain forms of heart disease.

523 Walnut Avenue

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Harry Feigenbaum, M.D.

Newark

Colloidal Oatmeal for Skin Eruptions*

Selection of a suitable soap is always difficult for patients with inflammatory or chronic skin eruptions. Dr. Feigenbaum suggests that colloidal oatmeal in a petrolatum base may meet the desiderata for an effective soap substitute.

In many inflammatory and chronic skin eruptions of the hands soap is contraindicated because of its irritating and defatting effect on the already aggravated skin. Even the mildest toilet soaps have a pH on the alkaline side. Normal skin pH is on the acid side. The normally acid pH of the skin plays an important role as a barrier against infection by organisms on the skin.

As a result, many detergents have been developed for use on irritated and sensitive skin, particularly for the hands. Various "mild," "superfatted" and "alkali free" soaps have also been advocated. In form and appearance they vary from liquids (some oily in character) and emulsions to solid cake forms which closely resemble the ordinary toilet soaps. Some lather, others do not, and some have added antiseptic chemicals.

For a soap substitute to be of value in inflammatory skin eruptions it should:

1. Be mildly acid or neutral in reaction.
2. Be non-irritating and, if possible, be soothing.
3. Be acceptable to the patient so that regular use is assured.
4. Not appreciably remove the normal sebaceous coating of the skin, particularly in the dry, eczematous type of eruption.

In 32 patients with various hand eruptions a preparation of colloidal oatmeal in petrolatum (Aveeno® Soap Substitute[1]) was prescribed in place of the soap or other skin cleanser they had been using. These patients were followed for periods of 1 to 6 months. Diagnoses were as follows:

1.	Neurodermatitis (localized)	3
2.	Eczematoid dermatitis	16
3.	Nummular eczema	3
4.	Dermatophytids	6
5.	Atopic dermatitis (disseminated neurodermatitis)	2
6.	Contact dermatitis	2

Of the 32 patients, 15 had used other soap substitutes previously, distributed as follows:

Acidolate® (White Laboratories Inc.)	9
pHisoderm® (Winthrop Laboratories Inc.)	3
Dermolate® (White Laboratories Inc.)	1
pHisohex® (Winthrop Laboratories Inc.)	1
Liquid Petrolatum	1
Aveeno Skin Cleanser® (powder form)	1

One patient used both Acidolate® and pHisoderm®.

Until the effectiveness and patient acceptance of the colloidal oatmeal-petrolatum product had been verified, no change was made in the definitive treatment of any of the patients.

No matter how beneficial a topical medication may be, it is of little value unless patients

*This work is from the Newark Regional Office of the Veterans Administration where Dr. Feigenbaum is senior dermatologist.

1. Supplied by the Aveeno Corporation, New York 19, N. Y.

use it. In general, smelly and messy applications find little acceptance. The usefulness of such effective applications as Vleminckx's solution[2] and crude coal tar is limited because it is frequently impossible to persuade patients to continue them for a sufficiently long time.[3]

RESULTS

1. All 17 patients who previously had been using soap and were changed to Aveeno Soap Substitute® showed significant decrease in such inflammatory signs as erythema, edema and oozing. In all cases, the regimen remained unchanged with the exception of the cleansing agent.

2. Twenty-nine of them (91 per cent) found the colloidal oatmeal-petrolatum product easy and convenient to use except when hands were very dirty. In general, it was acceptable for prolonged continued use.

3. Three patients did not like the product. One did not like any of the other soap substitutes because he felt that they did not cleanse as well as soap. The other two preferred a liquid type of soap substitute. None felt that the colloidal oatmeal in the petrolatum base was irritating to the skin or excessively greasy.

CONCLUSION

Colloidal oatmeal in petrolatum base (Aveeno Soap Substitute®) furnishes the physician with a non-irritating soap substitute generally acceptable by patients for continued and prolonged use. This product appears to meet all the criteria for an effective soap substitute. It has good cleansing qualities and is valuable in cases where the use of conventional soap and detergents is contraindicated.

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20 Washington Place

Oral Vitamin K During Anticoagulant Therapy*

Anticoagulant therapy with the coumarin and indandione derivatives has been made less hazardous by the demonstration that Vitamin K_1 and Vitamin K_1 oxide produce a prompt reversal of excessive hypoprothrombinemia.

Vitamin K_1 has become available for oral use. Its ease of administration is an advantage. The effectiveness of small doses of this form of Vitamin K_1 in the "damping down" therapy for excessive hypoprothrombinemia has been established. The oral tablet of Vitamin K_1 is an effective antidote for coumarin- or indandione-induced excessive prothrombinopenia.

This drug, in doses of 2.5 mg. to 20 mg., was administered to 75 patients in whom excessively elevated prothrombin-time values were produced by prothrombinopenic anticoagulant therapy.

In 15 per cent of the patients studied the prothrombin time returned to a safe range (35 seconds or less) within 12 hours after the oral administration of Vitamin K_1 in this dosage, and in 98 per cent of the patients within 24 hours.

The prothrombin time fell below the lower therapeutic level of adequate anticoagulation in 15 per cent of the patients at 12 hours following Vitamin K_1. Under such circumstances the administration of heparin ensured a continuing antithrombotic effect, until subsequent doses of coumarin or indandione agent again achieved an adequate hypoprothrombinemia.

Since most hemorrhages during anticoagulation occur in association with prothrombin-time values above 35 seconds, Vitamin K_1 tablets for oral use provide an additional safeguard in coumarin and indandione.

*Cosgriff, S. W.: Annals of Internal Medicine, 45:14 (July, 1956)

F. Clyde Bowers, M.D.

Meudham

Trends in Medical Services in Private Practice and Public Health*

Spectacular advances in public health and communicable disease control have focussed attention on the efficiency of our public health programs. However, the private practitioner has a role here, too, and it is often a forgotten role. In this timely talk, Dr. Bowers spotlights the private practitioner's part in this program.

Medical services in America in our present society would be almost non-existent, were it not for the private practitioner of medicine. It is his duty as well as his inalienable right to be concerned about public health. Indeed, until a few generations ago the private practitioner was the sole guardian of public health. Today, in an age of specialization, his has become a different role. This is as it should be and does not detract from his importance. Although he may not still be all things to all people, the private physician is rightfully considered by the vast majority of people as their sole advisor in matters of public health.

We now have medical specialists in Public Health who are doing an outstanding and commendable job. Their ranks include physicians, nurses, social workers, sanitary engineers, bacteriologists and others. In the present state of our knowledge these are essential to a properly functioning public health unit. Their duties and functions are largely defined by statute and they enforce the regulations as prescribed by law. In a great measure, they are responsible for the present enviable status of our nation's health. Without them it is inconceivable that we could have protected potable water supplies, food and milk controls, sanitary sewers, proper housing and hospital facilities, to mention but a few of the everyday things that most of us take for granted.

On the other hand, our public health people would be the first to agree that without cooperation of the private practitioner of medicine their tasks would be insurmountable.

For example, suppose for a moment that all private practitioners were to refuse to serve patients in the public wards and clinics of our hospitals. What a catastrophe! What a problem this would create for our public health officials! We would become a chaotic state, affected in all spheres of living. Our morbidity and mortality rates would rise, infectious diseases would increase, temporary indigents might become permanent indigents, the labor market would dwindle, industry suffer, and our morals would deteriorate. The possible detrimental effects upon society that such a decision may have might well tax the imagination of everyone. Yet this is only one facet of the role played by the private practitioner in the field of public health.

*Delivered March 27, 1957 at the Governor's Conference on Medical and Hospital Services.

It has often been said, and with some justification, that one of the best places for the spread of propaganda is the doctor's office. Since the physician is considered by most of his patients to be an authority on matters of health, they seek and abide by his opinions. The physician, in the confines of his private office, becomes a potent force in the medical and health education of the public. It is here that he teaches and administers preventive medicine, the real keystone to a good public health program. Still another area in which the private physician is busily engaged is the field of medical research, even though many times unwittingly. This is especially true in the reporting of diseases, supplying pertinent data on certificates of birth and death, registering his findings on insurance applicants. In many ways he contributes to the compilation of statistics which have significant public health implications.

Many physicians do not limit their activities for the public welfare solely to the private practice of medicine. A great number are engaged in service on Boards of Health, in schools, in service clubs dealing with the health and welfare of the community, and in legislative bodies helping formulate laws for the protection of the health of our people. In caring for ward and clinic patients and in other services, many physicians find themselves spending as much time or more in non-remunerative activities devoted to the health of the community than the time devoted to their private practice for which they are compensated.

Although it is seldom done, one might well ask "why does a physician so spend his energy and time when he could be devoting it to a more lucrative enterprise?" The answer, of course, is simple. Under our present system of democracy, the doctor is an individualist who may spend his time as he sees fit. And may heaven preserve this way of life because under no other system have the people fared so well. The medical profession is gratified at America's leadership in many things in this world, but is especially proud of its attainments in medicine. We offer the best opportunities for medical education, and in no area is this more true than in public health. But deprive us of our democratic way of life, take from us our individualism, give us a socialist state, and we will lose all of our advantages. The attractions that draw a person into the practice of medicine, aside from the dedication to heal, are the opportunities to be a free agent, to be an individual who can express himself and be heard, to be a fighter for something that is worthwhile without being ham-strung by rules and regulations, to be an advocate of laws that will do good for the greatest number of people—in a few words, to be a person learned in his profession who will devote himself voluntarily to the general welfare of mankind.

The private practitioner in this democracy of ours, being such an individual, will fight to maintain his present status. Most Americans, understanding this, will help defend his position. This is so, because if we believe in democracy we must also believe in freedom of enterprise, freedom of expression, freedom from regimentation. The private doctor has a selfish interest in the preservation of democracy because he is protecting his individualism; but, by so doing, he is also securing the autonomy of all. There are those among us who are trying to force the medical profession into governmental control, to destroy the private practice of medicine. If this should happen we will be well on our way to a socialist state, for regimentation of others will quickly follow. This would assure quick passage down the highway to a degenerate nation where the health of the common people would be of little concern to those in power. So, to guarantee the protection of the health of the American public and to improve upon it, we must strive to sustain our democratic way of life and with it the private practice of medicine.

As in all things, there is room for improvement in our public health activities. Although we can point with pride to our accomplishments, we have by no means reached the quintessence of success. We may never attain this acme of perfection but this should not deter us from trying. Many problems still face us, such as cancer, heart disease, arteriosclerosis,

many diseases and abnormalities of the central nervous system and traffic accidents, to mention but a few. All of these are matters of concern found within the domain of public health. Of course, there is no simple answer but, as has been demonstrated in the field of communicable diseases, the combined efforts of the public, the private physicians and government will go a long way toward eliminating some and reducing the deleterious effects of others.

IT WAS Edward Jenner, a private practitioner in England, who, in 1796 established the effectiveness of vaccination against small-pox. However, it was a dairy farmer, Benjamin Jasty, who first observed that dairymen, who acquired sores on their hands from the infected udders of cows, always escaped small-pox when a wave of the disease came along. Impressed by this, Jasty in 1774 vaccinated members of his family with pus taken from the infected teats of his cows suffering from cowpox, and found that those so vaccinated were immune to small-pox. But it was Jenner who established this procedure as a scientific fact for the prevention of small-pox. Thus, it was the joint work of a layman and a private physician that gave us small-pox vaccination.

Furthermore, governments, recognizing the effectiveness of this procedure, enacted laws making vaccination compulsory in schools, in travel, in the armed forces. Where the law is enforced, there is no small-pox. This is a prime example of what can be accomplished when a concerted effort is made by the public, the government and the private physician.

Again the virtual elimination of typhoid fever from our prevalent diseases was accomplished by the joint endeavor of several independent practitioners, public health officials and sanitary engineers. Where only pure and uncontaminated water is used, no typhoid exists. Such a water supply can be assured only by government control of the source and purification systems. Protection of individuals traveling into potentially infected areas is guaranteed by vaccination by their doctors. In times of flood and disaster, mass inoculations are performed by public health authorities and individual physicians.

Conquering tuberculosis is another example of how the trio of people, government and private physician united to defeat a deadly foe. The public has helped for years in supporting the Tuberculosis Association in its annual Christmas Seal drive, the returns from which have been used to support research, case-finding, mass x-rays, and hospitalization. Government has contributed by providing hospitals for the care of the afflicted, by enforcing quarantine laws, by making x-ray examination and tuberculosis testing mandatory in our schools. Researchers have produced effective drugs to fight this white plague, have devised better operative technics to heal certain types of the disease. The private practitioner, however, has been the primary force in detection and reporting of the disease and now, with the new drugs, the main dispenser of healing therapy.

THE venereal disease rate has been greatly reduced because the Surgeon General of the United States Public Health Service, Dr. Thomas Parran, twenty years ago was bold enough to talk publicly about these diseases, and thus remove the stigma which prevented infected persons from seeking medical assistance. He fought for laws making premarital and pregnancy serologic testing compulsory. Industry was encouraged to make such tests parts of their pre-employment physical examinations. These revolutionary measures were fully supported by the medical profession as a whole, but the success of such maneuvers depended upon the cooperation of the private practitioners. That they did join forces with the Surgeon General is now a matter of history. That such united effort proved effective in reducing the venereal disease rate is a matter of record. All of this was accomplished before the days of "miracle drugs," but it laid the ground-work for the discovery of previously unreported cases and thus made them available for treatment before it was too late. Today these diseases are curable if discovered

and treated early. If we are to continue to control venereal disease, it is essential that these regulations remain in force. Because of their effectiveness, we must not be lulled into complacency. Instead we should strengthen our efforts so that we may continue to benefit from the foresight and courage of Dr. Parran.

Currently we are experiencing a community drive to eradicate poliomyelitis. Everyone is familiar with the many years of research underwritten by public funds accumulated by the National Foundation, and culminating finally in an effective vaccine being administered in public clinics and by private physicians. Once again this is proof of the proficiency attained by the joint action of the public, the private physician and government.

Many other examples could be cited but these are sufficient to demonstrate that this approach is one solution of our public health problems. Since this is so, it is all the more imperative that we defend the right of the public and the private physician to participate in such a program. We must not be fettered by government control nor shackled by irresponsible despots. We must remain free to engage in the enterprises of our choice, free to help our nation prosper, free to seek an equity in that prosperity and free to help others in this same aspiration to independence. A free nation is a healthy nation because people living in freedom have the initiative and the desire to work together for the common good. That is why America today is the leader in medicine. Let us stay united as a free democracy so that the public, the private physician and the government may strive assiduously, cooperatively and amicably to reach the same goal—the best medical services in the world.

1 Mountain Avenue

Radio-active Iron*

Dr. Ross* discusses the use of radio-active iron (Fe-59) in hematology. Normally, Fe-59 is rapidly and almost completely incorporated in red blood corpuscles. Its utilization in kidney disease is slow and incomplete.

The reason for the anemia in leukemia was assumed to be the result of bone marrow function suppression. Studies with Fe-59 in lymphatic leukemia indicate a more-rapid-than-normal Fe-59 uptake (over twice normal). Radio-active chromium (Cr-51) labeled donor cells in these patients showed greatly shortened survival rates.

Some patients without anemia, but otherwise clinically indistinguishable from those with anemia, showed normal survival rates for donor cells.

The normal pattern for iron distribution is: (a) rapid disappearance from plasma (6 hours following injection); (b) maximum rise in marrow in 24 hours, (c) 100 per cent utilization in red cells at end of seven days. There is no significant change in the liver, spleen and heart. If Fe-59 is taken up by spleen in splenomegaly, hematopoeisis is occurring in spleen. If Cr-51 labeled cells are being too rapidly destroyed, the spleen will show increased radioactivity. This provides basis for differentiation between types of splenomegaly.

About 20 per cent of patients admitted to general hospitals in the United States are anemic. Most are iron deficient. Iron in most foods is poorly absorbed. Inorganic, medicinal iron is much better absorbed.

Studies in survival rates of Cr-51 labeled donor cells indicate that ACD solution is still the best preservative for whole blood.

Radiocobalt labeled vitamin B_{12} useful in diagnosing pernicious anemia, even in remission. It is not absorbed in pernicious anemia unless gastric juice is given.

*Before the Subcommittee on Atomic Medicine (84th Congress) Dr. Joseph Ross of the University of California testified on June 1, 1956. Here is an abstract of his testimony prepared by Dr. Paul DeR. Kolisch of Phillipsburg, N. J.

William Rubin, M.D.

New Brunswick

Ocular Muscle Anomalies in a General Hospital Eye Clinic

Dr. Rubin says that the orthoptic unit at Middlesex General is the only organized hospital clinic for orthoptics in the entire state. If this is so, this little paper points up a challenging possibility for every ophthalmologist in New Jersey.

At the Middlesex General Hospital in New Brunswick an orthoptic clinic has been established to which all recognized ophthalmologists may refer patients with ocular muscle anomalies. The clinic has been operating since the fall of 1955 with two orthoptic technicians. Patients are admitted only upon recommendation from an ophthalmologist. Fees are moderate. No fee is charged to indigents. What began as a one day a week clinic, now meets four days a week.

With the increasing awareness that cosmetic improvement is not enough, it is anticipated that every child in whom we hope to develop or strengthen binocular single vision and fusion will be afforded the benefit of orthoptics. Not in all patients can this happy faculty of fusion be established. Where this function cannot be developed we accept the compromise of cosmetic improvement only. To deny the importance of visual training is to be unwilling to admit the value of guided exercise in coordinated voluntary and involuntary muscular activity. We have found by repeatedly creating normal patterns of seeing, that the individual is given an opportunity to recover skills which may be of inestimable value to him in later life.

One often hears from eye physicians sincere expressions of regret at not having facilities to care fully for the child with a squint or the adult with "tired eyes"—the one with 20/20 vision but insufficient convergence to read comfortably. A feeling of inadequacy has plagued many of us from the moment we began to grapple with the problems of cross-eyed children or with the muscle imbalances of adults. We have deliberately been vague with our advice to patients, their pediatricians or their family physicians. With such remarks as "Wait until he gets older," "She may outgrow it," valuable time has been lost in which the unnecessary visual impairment of amblyopia and the unfortunate sacrifice of binocular single vision may have been prevented.

The cross-eyed individual is often blind in one eye to a greater or lesser degree. Downing[1] found that in 60,000 selectees for the U. S. Army 66 per cent of all partial uniocular blindness was due to squint. Many jobs in industry are automatically closed to people with uniocular vision or inadequate binocular vision.

Many patients have had glasses prescribed

1. Downing, A. H.: Archives of Ophthalmology, 33:137 (Feb. 1945)

or surgery performed with the hope and prayer that neither "too little" nor "too much" was done. This very lack of precision sometimes causes patients to seek treatment from unapproved sources. Many difficult problems remain to be resolved in ocular muscle imbalances. However, only by persistent and patient investigation of the physiology and pathology of the ocular muscles, as for example, in electromyography will we come closer to correct analysis. In this newest method of ocular muscle study the differences in electrical potential upon stimulating a specific muscle is recorded in the form of a graph. Muscle defects can, to some extent, be detected from the nature of the tracing. We are, of course, quite far from the accuracy of the electrocardiogram or electroencephalogram.

To help achieve our goal the orthoptist, working in close coordination with us, occupies a position which may be compared to that of a skilled physiotherapist or a competent coach. The athletic coach spurs his players on to greater accomplishment. By pointing out unsatisfactory methods, by encouraging more skillful performances, by friendly competition and by the reward principle, the orthoptic technician, as a coach, has the responsibility and the opportunity for making important contributions. An orthoptist, who by her training and personality is suitable to her task, is an important link between patient and physician. She makes regular progress reports, submits recommendations prior to surgery and is most helpful in stabilizing gains made from surgery. We may wish to use cycloplegics, miotics, or corrective lenses of any description. Still the technics of orthoptics to stimulate or create normal seeing habits cannot be replaced or substituted. It is hoped that more effort will be made to establish adequate centers for the treatment of ocular muscle abnormalities.

184 Livingston Avenue

Does Medical Progress Mean More Heart Disease?

More Americans than ever before are now living long enough to die from heart disease. So writes George Bugbee, president of the Health Information Foundation in May 1957, *Progress in Health Services*. Disorders of the heart, blood vessels and related organs, caused over 850,000 deaths last year—more than half the total number of deaths in this country. In 1900 these diseases caused only about one-fifth of all deaths.

"In a sense," writes Mr. Bugbee, "the increasing prominence of heart disorders is a reflection of medical progress. With many once-feared infectious diseases now under control, more Americans are living to an age where they are more likely to become subject to heart disease and other degenerative disorders."

"Substantial progress has been made against premature death from many forms of heart disease, notably conditions of infectious origin — rheumatic and syphilitic heart disease and subacute bacterial endocarditis. But coronary heart disease remains a major unsolved problem."

Although disability from heart disease is apparently more prevalent among women, it causes more deaths among men. In fact, 75 per cent more men than women died from heart disease in 1955, as opposed to 15 per cent more in 1900. The disparity is highest between the ages of 35 and 49.

One frequently-stated explanation for this puzzling trend is that "men are thought to be particularly subject and perhaps particularly vulnerable to strains and pressures of modern life, factors presumed to be important in causing the disease."

Coronary heart disease apparently flourishes where living conditions are highest, diets richest and psychological pressures heaviest—in other words, in the type of environment that seems to typify modern America.

Charles H. Hall, Jr., M.D.

Paterson

Dental Anesthesia in Protracted Cases*

A SAFE OFFICE PROCEDURE

A patient who needs prolonged dental anesthesia presents a special problem. In theory, protracted anesthesia is a hospital, not an office, procedure. In practice, few hospitals are equipped for dental surgery, and fewer still would give up precious surgical beds for this service. Dr. Hall and his group suggest that one answer might be for a trained anesthesiologist to be available in the dental office. He shows the drugs and equipment needed and describes the technic.

The patient who requires prolonged general anesthesia for protracted dental work presents a challenging problem for the dental surgeon and the anesthesiologist. Any patient requiring anesthesia for more than fifteen minutes falls into this category.

The character of the patient may be the factor that determines the necessity for general anesthesia. An example is the child who is too young to cooperate for long sessions in the dental chair. Many cases of extensive dental caries are seen in children under the age of six. These youngsters can be controlled for little more than a few minutes at a time. Preparing and filling twelve or more carious teeth would require repeated visits to the dentist, each one of which would entail tedious preparation and coaxing. Dragging this over a period of months results in a haggard dentist, a harassed parent, and a "nervous," frightened child. Should the procedure prove painful, as occurs in pulpotomy, the difficulties are compounded. All too frequently the deciduous teeth are permitted "to fall out by themselves" rather than continue this procedure, and early loss of the deciduous teeth results in malocclusion and the subsequent necessity for orthodontia. The retarded child may be even more uncooperative and general anesthesia for this patient might be mandatory.

The second category of patients is the frightened older child or the neurotic adult who will not or cannot cooperate because of emotional instability or because of previous painful experiences, real or imagined. Everyone has seen the tearful, trembling individual who breaks out into a cold sweat on approaching the dental chair.

The type of dental procedure may be the factor requiring general anesthesia. Some procedures are lengthy; for others, the time needed cannot be estimated in advance. Some may be unsuitable for regional anesthesia. Impacted molars and bicuspids, apicoectomies, multiple extractions, particularly of the anterior teeth and excision of odontomata or dentigerous cysts are a few examples.

*Read before the Section on Anesthesiology, of The Medical Society of New Jersey, May 1, 1957. This work is from the Anesthesiology Department of St. Joseph Hospital, Paterson, N. J. This paper represents the collaboration of Edward T. Lawless, M.D., Francis E. Kelly, M.D., Robert Mulholland, M.D., Peter Tucci, M.D. and L. Vincent Varallo, D.D.S. with the senior author, Dr. Hall.

Most dental procedures are completed under regional anesthetic technics. The dental surgeon is the master of intra-oral block anesthesia and more than 90 per cent of all dental procedures requiring anesthesia are carried out in this manner.

General anesthesia in dentistry preceded its use in surgery. Indeed, the first general anesthetic administered in the United States was given by Dr. William T. Morton, a dentist. Our first anesthetic machines were dental machines manufactured by the S. S. White Co. Interest in general anesthesia by dentists for dentistry has been unflagging. Usual dental procedures that require but a few minutes for completion have been adequately and safely handled by dentists using all of the agents and technics known to modern anesthesiology.

The protracted case, however, poses a more difficult problem. The usual methods of maintaining an adequate airway and an even plane of anesthesia, of closely observing the responses of the patient to the anesthetic and the procedure, require the undivided attention of a person skilled in anesthesiology. The only technic that can be used with safety is endotracheal intubation. Because of the need for electrical equipment, the agents must be nonexplosive.

In 1954 Harry Slater, M.D., described a technic[1] of endotracheal intubation of children in the dental office. We have followed his technic with some minor modifications, and have followed the same principles in the care of adults.

THE patients whom we anesthetize in the dental office can be classified as Risk I. The presence of medical complications requires hospitalization of the patient or the use of regional anesthesia.

The equipment and drugs used are enumerated in the table. The equipment is easily transportable. With the exception of the anesthetic machine and tanks of gases, it all fits into a moderate sized tool box which can be obtained in any hardware store. The machine itself is a two gas portable model. We use a McKesson machine, but all major manufacturers have portable machines available. The gases are supplied in "B" tanks which are easily transported and supply adequate amounts of gas.

In children we use the premedication suggested by Dr. Slater and listed in the table; *i.e.* pentobarbital and secobarbital rectally. Adult patients are not premedicated except in the case of the extremely "nervous" patient,

TABLE OF EQUIPMENT

1. Portable anesthesia machine, two gas model, with nitrous oxide, oxygen and vaporizers for trichlorethylene and other volatile agents.
2. Adequate suction; that provided by the saliva ejector of the dental unit is insufficient; electrically driven suction or water tap Venturi type is needed.
3. Suction tip and suction catheters.
4. Nasal inhalers; adult (1); child (1).
5. No-rebreathing masks; adult (1); child (1).
6. Pharyngeal and nasal airways, adult and children's sizes.
7. McKesson Bite Blocks; 2 small, 2 medium, 2 large.
8. Gauze packs.
9. Laryngoscope with small, medium and adult sized blades.
10. Trichlorethylene; succinylcholine chloride 2%: Sodium pentothal or methitural; distilled water; normal saline 250 cc. and disposable i.v. tube; jelly; tourniquet and alcohol sponges; atropine.
11. "B" tanks of oxygen 3; nitrous oxide 3.
12. Syringes; 3-2cc; 3-5cc; 2-20cc.
13. 20 and 21 gauge needles.
14. Stephens-Slater or Digby-Leigh valve.
15. Foregger expiratory valve.
16. Rebreathing bags; 2 litre-1; and 3¾ litre-1.

1. At the Graduate Assembly of the New York State Society of Anesthesiologists.

where we use pentobarbital. All patients refrain from solid food for 10 hours prior to the scheduled time of anesthesia, and from clear liquids for five hours.

An adequate history is taken, the heart and lungs of all patients are examined.

THE CHILD PATIENT

THE pediatric patient is placed in the dental chair in a semi-sitting position, the hands beneath the buttocks. He is not otherwise restrained. A Slater no-rebreathing mask is gently lowered to the patient's face. Nitrous oxide and oxygen are administered at a 6 to 2 rate. If a McKesson machine is used a 75 per cent mixture of nitrous oxide is administered. As unconsciousness occurs minimal amounts of trichlorethylene are added to the mixture. When the first plane of third stage is reached succinylcholine is given intravenously, ¼ milligrams per pound of body weight. Nasal intubation is carried out with an appropriate sized tube, under direct vision. A dental bite block is then inserted while the jaw is still relaxed, and the patient is ventilated with oxygen until spontaneous respirations recur, then the gas mixture is resumed. A non-rebreathing system using a Digby-Leigh or Stephens-Slater valve connected to a reservoir bag serves for maintenance. Before surgery is begun a pharyngeal pack is loosely placed at the base of the tongue to prevent detritus from falling into the pharynx. Motion of the patient's head is avoided, since the very light plane of anesthesia may result in "bucking" on the endotracheal tube. If the head must be moved it is done slowly and gently.

The dentist then proceeds to prepare and fill the teeth. He completes one quadrant of the mouth before proceeding to the next. When half of the mouth has been completed, a second bite block is inserted before the first is removed. The plane of anesthesia is light enough for the patient forcibly to close his mouth if this precaution is not taken.

Upon completion of the dental work the mouth is carefully cleaned of amalgam, blood or mucus before the pharyngeal pack is removed. When this has been done the pack is removed and the lower pharynx is aspirated. The endotracheal tube is removed quickly during expiration.

Recovery is prompt. The patient reacts almost immediately. He is then transferred to the recovery bed for about fifteen minutes after which he is taken home. An intelligent adult is instructed to keep him quiet for the remainder of the day and a light fat-free diet is advised. Any tendency toward nausea is thus minimized.

THE ADULT PATIENT

IN THE adult patient our procedure differs somewhat. The patient is not premedicated prior to his arrival at the dental office. An intravenous of 5 per cent glucose in distilled water is started and 1/150 grain of atropine sulfate is administered. Induction is accomplished with a 2½ per cent solution of sodium pentothal or methitural until the eyelid reflex is lost. Then nitrous oxide-oxygen is administered using an adult no-rebreathing mask. When first plane of stage III is reached 40 to 50 milligrams of succinylcholine are given and nasal intubation is done as soon as relax-

TABLE 2. PREMEDICATION IN CHILDREN: SECOBARBITAL OR PENTOBARBITAL

Age	Oral	Rectal
1-3 years	gr. ¼	gr. ½
3-5 years	gr. ½	gr. 1
5-8 years	gr. ¾	gr. 1½
8-12 years	gr. 1	gr. 2
12 plus	gr. 1½	gr. 3

TABLE 3. ENDOTRACHEAL TUBE SIZES FOR CHILDREN FOR NASAL INTUBATION

Age (yrs.)	French	Magill	Portex	Length Centimeters
1- 3	20-22	1	2	12
3- 5	23-24	3	3	17
5- 7	26	4	4	19
8-12	27-30	5 to 7	5 to 7	21
12 plus	31-38	8 to 9	8,9,10	22

ation is complete, using direct vision. A semi-closed system without absorption is used, utilizing a "pop-off" valve. The rate of flow of gases must be maintained in a volume to permit the reservoir bag to be slightly distended during expiration. Minimal amounts of trichlorethylene may be added, or intermittent injections of the intravenous barbiturate. It has been our experience that the incidence of nausea postoperatively although never alarming, is increased with trichlorethylene. From this point the procedure is carried out as with the child. Again recovery promptly follows extubation. The patient walks from the dental chair to the recovery bed within 5 minutes, although assistance is necessary. Within 30 minutes, he is able to return home. We insist that the patient be taken home by car and that he remain at home under supervision for the remainder of the day.

HOSPITAL VS. OFFICE

THE technics described permit protracted dental cases to be handled in the dental office. They do not ignore the necessity for control of the airway and for adequate ventilation during extended periods of anesthesia. They do, however, require the services of an individual expert in the use of these technics and procedures. Anesthesiologists, if they can struggle free of their hospital duties, are certainly in a position to provide this service.

It has been stated that any extended period of anesthesia should be done only in a hospital; but few hospitals are equipped to supply the needs of dentistry. The constant demands for surgical beds in hospitals today make it almost impossible for the dentist to admit any but the most complicated cases. Furthermore, Blue Cross, Blue Shield and other insurance programs rarely cover the cost of hospitalization for dental work. Insurance plans at the present time do not provide for payment for dental care itself. Hospitalization would add an expense to the patient that is almost equal to the fee of the dentist and the anesthesiologist combined.

The methods described permit the dentist to work in familiar surroundings, with all of the equipment he needs. This service is wanted by dentists and it can be supplied by trained anesthesiologists. It is urgently necessary for limited types of patients until hospitals or other agencies provide better facilities.

St. Joseph Hospital

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Heribert J. Schaefer, M.D.

Summit

Adenomatoid Tumors of Epididymis*

A Consideration of Their Histogenesis

This brief but original study won the Harrison S. Martland Award for 1956. It indicates that adenomatoid tumors of the epididymis are probably of mesothelial origin — a controversial problem in urologic pathology.

In 1915, Sakagushi[1] first described an adenomyoma of the epididymis which fits current concepts of adenomatoid tumors. Until recent years, it was assumed that such tumors were rare. Thus, in 1951, Longo, Thompson and McDonald[2] reviewed the world literature and could find only 134 cases, three-fourths of which were benign. Of the benign cases, 53 per cent were adenomatoid tumors. Golden and Ash[3] reported 89 adenomatoid tumors. Many new cases have been added since, and Herbut[4] states that adenomatoid tumors head the list of benign neoplasms of the epididymis.

The non-committal term "adenomatoid tumor" is used for a group of neoplasms showing apparently similar clinical and histopathologic manifestations. Many favor the classical description used by Golden and Ash,[3] who state that these tumors "are made up of a fibrous stroma in which are found numerous disoriented spaces lined by cells which may resemble endothelium, epithelium or mesothelium." From this description, it is immediately apparent that there are no exact microscopic criteria for the diagnosis of these lesions. Golden and Ash[3] said that the histogenesis was obscure. Indeed many investigators question whether adenomatoid tumor is really a neoplasm. Stout[5] has emphasized the difficulty in differentiating between an inflammatory lesion of the epididymis and a true neoplasm. Golden and Ash,[3] and Wyatt and Khoo[6] reject the concept of endothelial origin because the lesions are not present at birth. Furthermore, the growth is not a sclerosing process. Rubaschow[7] and others say that tumors of the epididymis, in general, may arise from cells of the epididymal tubules, the Wolffian body, the myotome anlages or from adjacent stromal tissue such as lymph vessels and the fibrous connectives tissue. The epithelial origin of the tumors was also favored by Golden and Ash.[3] The supporters of an epithelial origin, however, have not agreed as to whether the tumor arises from the

*Read February 26, 1957 before the Essex County (N.J.) Anatomic and Pathologic Society.

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4. Herbut, Peter: *Urologic Pathology.* Philadelphia 1952. Lea and Febiger, v. 2., page 1075.
5. Stout, A. P.: Proceedings of the New York Pathologic Society, 17:129 (July) 1917.
6. Wyatt, J. P. and Khoo, Priscilla: British Journal of Urology, 22:187 (March) 1950.
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epididymis proper, or from the Wolffian body, or from Muellerian vestiges. The structure of these tumors, their epithelial arrangement and their distribution correspond to the appearance and sites of Muellerian vestiges. This was considered to be conclusive grounds for epithelial origin. The mesothelial origin was first suggested by Masson[8] and supported by Sundarasivarao.[9] The brush borders of the cells lining the gland-like spaces and the supranuclear diplosomes which are often noted are also characteristic of mesothelial cells. Evans[10] even asserted continuity of the tumor to the serosal surface. Many other cases were reported as mesotheliomas of the epididymis.

New data have accumulated in support of their mesothelial origin. Studies of adenomatoid tumors in recent years have stimulated increasing interest in other lesions that closely resemble tumor but showed the cytomorphologic characteristics of mesothelial granulomas. Various names have been applied to these lesions including adenomyoma, adenofibroma and angiomatoid tumor. Many such tumors were diagnosed as lymphangioma or angiofibroma. They may all actually belong in the category of adenomatoid tumors.

MATERIAL AND METHODS

The present study is an attempt to orient the histologic findings of ten new cases of adenomatoid tumor with regard to their cytomorphologic features, their locations and clinical significance. It seemed worthwhile to study also all autopsied males in our hospital since 1954 in an attempt to identify remnant mesonephric structures. It was hoped that such studies would shed some light on the problem of whether mesothelial or epithelial elements are involved in the formation of adenomatoid tumors. As the result of this study, tumor-like nodules were found at the tail of the epididymis in 10 cases. Histologic sections proved that these nodules were not tumors. Two cases diagnosed as mesothelial granulomas of the tunica vaginalis were encountered in routine surgical specimens. The 10 cases of adenomatoid tumors were selected from the files of the Department of Pathology of Overlook Hospital, Summit, N. J., of the Department of Pathology, Orange Memorial Hospital, Orange, N. J. and the Department of Uropathology, Presbyterian Hospital, New York. All were reviewed and the diagnoses confirmed by Dr. M. M. Melicow. The autopsy cases and the 2 mesothelial granulomas were selected from the files of Overlook Hospital. The tissue sections were stained with hematoxylin and eosin, selected sections with Masson's trichrome and Hortega-Foot's reticulum stain.

COMMENT

In 9 of the 10 cases of adenomatoid tumor, the histories were evaluated. In one case the history was not available. Three were completely asymptomatic and the tumors were found incidentally, two during a routine physical examination and one at autopsy. Pain and scrotal swelling developed in the other patients over a variable period ranging from 2 days to 6 years and were accompanied by development of hydroceles of the tunica vaginalis. Three had symptoms of epididymitis with generalized thickening of the tunica vaginalis due to chronic inflammation. No localized tumor was elicited clinically; but the diagnosis of adenomatoid tumor of the tunica vaginalis was made on tissue sections. In 7 cases, the tumor was localized at the lower pole of the epididymis, was completely separated from the testicle, and measured on the average 1 to 1.5 centimeters in diameter.

The histologic sections in all cases showed tumor tissue with a fibrous-collagenous ground substance which enmeshed variously-sized, irregularly-shaped gland-like spaces that sometimes were coalescing. The cellular lining of these structures showed a variegated picture. In some areas the lining cells were flattened, in others they were cuboidal. Notable characteristics were: (1) formation of intercellular bridges; (2) vacuolization; and (3) what appeared to be mucoid or hydropic

8. Masson, P. *et al.*: Revue Canadienne de Biologie, 1:720 (September) 1942.

9. Sundarasivarao, D.: Journal of Pathology and Bacteriology, 66:417 (April) 1953.

10. Evans, N.: Journal of Urology, 50:249 (March) 1943.

degeneration of the cells. In many areas, solid groups of vacuolated cells with a signet-ring appearance were firmly embedded in the connective tissue matrix and showed no gland-like lumina, except in those areas where mucoid degeneration formed pseudolumina with the remaining peripheral layer of cells simulating an epithelial lining. Many of these cells were hydropic and had lost their borders. Particularly in peripheral portions of the tumors, gland-like spaces were lined by cells resembling mesothelial cells with characteristic ballooning and occasionally fine brush borders were noted. In many instances, the stromal matrix presented foci of fibrinoid degeneration involving the collagen. In all sections either nodular lymphocytic aggregates or diffuse lymphocytic cell infiltration were noted. In many sections, the vascularity of the tumor tissue was conspicuous. Trichrome stains revealed that smooth muscle fibers also participated in the formation of the ground substances. Except for a few fragmentary strands in some areas, reticulum stains revealed an almost complete absence of any circumferentially-arranged fibers about the gland-like spaces. Peripherally many disoriented lacunar spaces were haphazardly distributed within a fibrous connective tissue stroma. In none of the gland-like structures were myo-epithelial cells found. This suggests that these are not true glands.

In two cases the adenomatoid tumors were embedded in the tunica vaginalis with direct continuity to the serosal surface and were also characterized by a downward proliferation of mesothelial cells that were accompanied by newly proliferated fibroblasts in some areas. These areas in particular are interpreted as evidence that these structures have been derived from the serosa of the tunica vaginalis.

Melicow[11] believes that these neoplastic mesothelial structures may have been derived from remnants of peritoneum that accompanied the testis in its descent. It is known that the processus vaginalis of the peritoneum forms a tubular evagination of the iliac fossa in front of the attachment of the gubernaculum testis; and also that the ligamentum testis represents a terminal portion of the mesonephric duct extending into the processus vaginalis. Thus, remnants of peritoneum or mesothelium may become enmeshed during the formation of the ligamentum testis. One other possibility was suggested by Sundarasivarao[9] who observed serosal metaplasia originating from the serosal covering of the testis and the adnexa which are usually covered by mesothelium. This may result in formation of serosal plaques and downward proliferation of cells extending into the connective tissue. Finally, these cells may undergo cystic or degenerative changes, show proliferative activity and form columns of cells which are choked by the fibrous tissue matrix. These cells may have a pleomorphic appearance and their pattern may be suggestive of invasion.

In the 10 autopsy cases where tumor-like nodules were encountered at the tail of the epididymis, subsequent histologic sections did not yield any evidence of tumor. The sections largely presented collagen and fibrous connective tissue with a smooth muscle component of the gubernaculum and gland-like spaces lined by mesothelial cells. Occasionally, nests of mesothelial cells were encountered in the subserosal connective tissue. Some of these cells showed mucoid degeneration. However, no active cellular proliferation was encountered and the stromal matrix appeared to be rather loose and vascular. Of particular interest in some sections were the presence of stalked hydatids, at the bases of which gland-like serosal inclusions were found; some of these connected with the serosal surface.

One other interesting observation was made in a surgical case where a large hydrocele of the tunica vaginalis and numerous hydroceles of the spermatic cord were present. The mesothelium was disorganized in several areas and showed downward proliferation with numerous variously-sized gland-like or cystic spaces embedded in granulation tissue. Occasionally, pseudostratification of the mesothelial cells was noted. Several sheets of cells showed mucoid degeneration. These cells had a signet-ring appearance and in many areas an increased amount of foamy cytoplasm with coalescence of neighboring cells was noted. These findings resembled, in some areas, closely an adenomatoid tumor or mesothelioma. However, the predominance of granulation tissue and prevalence of acute and chronic inflammation were thought to be primarily responsible for the mesothelial cell proliferation. Accordingly the lesion was classified as a mesothelial granuloma. Similar findings were encountered in one other case.

11 Melicow, M. M.: Personal communication to the author.

SUMMARY AND CONCLUSION

1. Study of ten new cases of adenomatoid tumors revealed a similarity in the histologic pattern. In two, the tumor was in direct continuity with the serosal surface and was also characterized by a downward proliferation of mesothelial cells. Mucoid degeneration of actively proliferating mesothelial cells embedded in a rather dense fibrous stromal matrix gives the tumor a typical appearance. However, mucoid and foamy degeneration of mesothelial cells were also observed in granulomatous lesions of the tunica vaginalis and were concomitant with downward proliferation of mesothelial cells. The dense fibrous and sometimes collagen connective tissue matrix seems to be most likely responsible for the degeneration of cells in both the neoplastic and granulomatous lesions. Chronic inflammatory reaction was present in all cases and possibly plays a role in the proliferative activity of the mesothelial cells.

2. The typical location of adenomatoid tumors in the area of the tail of the epididymis or along the mesonephric ducts led many authors to believe that the adenomatoid tumors were of epithelial origin. However, remnants of peritoneum accompany the testis in its descent and may be found in the gubernaculum testis. Sections through these areas in the 10 autopsy cases, proved not to be tumor, revealed such mesothelial inclusions. This would explain the presence of adenomatoid tumors in these locations. Since the tumors were neither connected with the testes nor comprised of epididymal elements, adenomatoid tumors should be regarded as autonomous neoplasms of mesothelial origin.

The author gratefully thanks Dr. M. M. Melicow for case material from his files, and for the time he devoted to reviewing all these cases. Thanks are also due to, and hereby expressed to Dr. A. R. Abel for the material which he generously contributed. Finally, I must thank Dr. G. L. Erdman for encouraging me in this undertaking and for help in revision of the manuscript.

193 Morris Avenue

Radio-Isotope Medicine

Dr. Friedell* discusses the measurement of cardiac flow by use of radio-active iodine-tagged albumin. The method allows measurement of cardiac flow and of blood volume in intact animal.

Tumors of the eye take up radiophosphorus selectively. A special instrument has been devised to explore the posterior portion of the globe. Clinical application has resulted in the accurate diagnosis of tumor in 79 of 80 cases. The one failure was early in the series when the surgeons did not accept the radiation findings.

Rose Bengal and tetraiodophenolphthalein, tagged with I-131, are the most promising vehicles for the selective deposition of radio-isotopes in the liver. Nonfunctioning areas (notably tumors) can be identified.

*This is a resume of testimony by Dr. Hymer Friedell of Western Reserve. Dr. Friedell was testifying before a Congressional subcommittee on atomic medicine. Dr. Paul Kolisch of Phillipsburg, N. J., prepared this abstract.

Intestinal Obstruction in the Newborn*

The prime symptom of obstruction in the newborn is vomiting. If this occurs immediately after birth, consider: atresia of the duodenum, jejunum, ileum, or colon; malrotation of the gut; congenital bands or adhesions; imperforate anus. After two weeks, hypertrophic pyloric stenosis is most common. After a month, strangulated hernia and intussusception predominate. Diagnosis is made by flat plate of the abdomen, inverting the infant to demonstrate gas. Operation is indicated in obstruction. The earlier the diagnosis is made, the better. The operative mortality, in experienced hands, varies from about 50 per cent for congenital atresia to one per cent for hypertrophic pyloric stenosis. Recognition of early stages of obstruction has cut down the mortality in the last few years.

The operative technic involves bypassing the obstructive site by whatever -ostomies are necessary, rather than resecting part of the gut in these very young patients.

*Brooks, B. F.: Journal of the American Women's Medical Association, 11:50 (February, 1956)

Alfred D. Summers, M.D.

Princeton

Cerebral Bruit in Pregnancy*

Enlarged cerebral vessels associated with pregnancy can sometimes produce a bruit which suggests aneurism. The case here recorded appears to be unique in medical literature.

This case report is being recorded because of its apparent rarity. A search of the literature failed to uncover a single comparable case in medical history. Subarachnoid hemorrhage in pregnancy is not uncommon. Many cases of aneurism of the Circle of Willis, in association with pregnancy, have been reported. However, this patient's history and neurologic findings seem to be unique. It is unfortunate that the angiogram studies could not be completed.

A 22-year old married primigravida first came under my observation in October. She gave a history of amenorrhea since July 4. Examination revealed a normal intrauterine pregnancy of about twelve weeks' gestation. Estimated date of delivery was April 11. Past history was negative for serious illness. She had had a tonsillectomy in childhood and an appendectomy in 1949. She was Rh negative, Group O. Serology was negative.

The ante-natal course went smoothly and without incident until the 40th week of her pregnancy. At that time the patient telephoned me to say that she had noticed a "noise" in her right ear which was intermittently present and more pronounced following exertion. She described the noise as "squeaking" and loud enough to disturb her when trying to sleep. Consultation with an otolaryngologist ruled out adventitious sounds arising from contractions of muscles in the middle ear. The otolaryngologist made a tentative diagnosis of aneurism of a cerebral vessel, probably in the Circle of Willis.

During the next two days, the bruit became constant and much more troublesome. It could be heard in the region of the right ear without a stethoscope. The noise was high pitched and seemed to be synchronous with the heart beat. While awaiting a neurologic consultation, she went into labor and was admitted to the hospital. By the time the neurologist arrived, she had developed some new symptoms. At first she complained of numbness in her lower lip, a loss of sensation in the tip of her tongue and some difficulty with visual acuity. Within two hours she had a partial right-sided facial paralysis, some difficulty in moving her right arm and right leg and a suggestion of a Babinski reflex on the left.

At about this time, the late Dr. Joseph Yaskin arrived to see her in consultation. Dr. Yaskin reviewed the history and the onset of her present illness. His neurologic examination revealed an audible bruit over both temples and over both mastoid regions. There was no bruit over the right carotid artery. "The bruit," he wrote, "was synchronous with the heart beat although one had the feeling that it was more or less a continuous bruit." Compression of the right carotid artery did not stop the bruit. The rest of the examination disclosed the following:

(1.) Anesthesia for pain involving the right fifth nerve complex, extending down to the third cervical level.

(2.) Incomplete peripheral facial palsy on the right.

(3.) Definite dysergia of the right arm and right leg.

(4.) A questionable left Babinski.

Dr. Yaskin felt that the most likely diagnosis was an arteriovenous shunt, probably an anomaly over the right side, most likely in the distribution of the right basilar branches. Other diagnostic possibilities were discussed, including a blood vessel neoplasm and multiple sclerosis. Dr. Yaskin agreed that cesarean section should be done before any further strain on the blood vessels occurred. At this time the cervix was only one centimeter dilated and labor was not active. The cesarean was done rapidly under minimum cyclo-

*From the Department of Obstetrics at the Princeton (N.J.) Hospital.

propane anesthesia. The baby was very large, weighing 9 pounds, 14 ounces (4500 Gms.). Mother and baby made a good recovery and were discharged on the eighth postpartum day. All neurologic signs and symptoms disappeared by the end of six weeks. The symptoms and abnormal neurologic findings cleared up in the reverse order in which they appeared. The head bruit was the last to disappear. This occurred eight weeks following delivery. For some time after that, this young woman had a return of her ear noise when she became emotionally upset or following strenuous exercise.

Six months later, Dr. Yaskin and Dr. Robert Groff of the Graduate Hospital of the University of Pennsylvania started arteriogram studies of the cerebral vessels. The right carotid was injected but the lesion was not visualized in any of the vessel branches arising from the right carotid. Further studies of the left carotid and vertebrals were contemplated but have not been carried out because of objections by the patient's husband and father. At the present time, three years later, this patient is, to all intents and purposes, entirely well. She carries on her usual household duties and leads a normal, active social life. She has been advised against future pregnancies.

A normal, healthy young primigravida developed a cranial bruit in late pregnancy. During labor she developed a right sided facial palsy and other neurologic changes. Cesarean section was done to avoid rupture of a presumed aneurism of a cerebral vessel. She made a good recovery and all her symptoms disappeared as the effects of enlargement of vessels, due to pregnancy, regressed.

I am indebted to Dr. Ralph J. Belford and Dr. Ashby Adams, as well as to Dr. Joseph Yaskin and Dr. Robert Groff, for their help in the management of this case.

71 Palmer Square West

Obituaries • • •

DR. RICHARD GOOD

A heart attack sustained on May 23 proved fatal to Dr. Richard Good, a member of the Hudson County Medical Society. Born in Union City in 1902, Dr. Good was graduated in 1929 from Cornell University Medical School. He interned at the Methodist Episcopal Hospital in Brooklyn in 1929 and 1930 and then returned to New Jersey to become associated in private practice with his father, Dr. George Good of Union City. While interested in all phases of medical practice, Dr. Good was primarily a surgeon and was Attending Surgeon at Christ Hospital in Jersey City and also at the North Hudson Hospital in Weehawken. Dr. Good was active in civic affairs in the Bergen-Hudson County area.

DR. IRVING MAISEL

Each year the Beth Israel Hospital interns hold a dance at a Newark hotel to raise funds for a welfare fund. The 1957 dance, held on May 25, was shattered by the death there of Dr. Irving Maisel, an assistant attending urologist at that hospital. Dr. Maisel was only 42 years old at the time of his fatal coronary attack. He was also on the staffs of Irvington General, VA Hospital in East Orange, St. James Hospital and the Martland Medical Center in Newark. Born in Newark, he was graduated from the Louisiana State University Medical School in 1938. He interned at Newark Beth Israel and then went into active service with combat troops in the Army in New Guinea. He was awarded a medal for gallantry in action. After his release from the army, Dr. Maisel did graduate work in urology, became a board diplomate in that specialty and entered private practice in Newark.

Historical Article • • •

Sidney Friedenberg, M.D.

Camden

Tobias George Smollett, M.D.

Pamphleteer, Playwright and Proctologist

This brief vignette throws some light on one of the lesser known physicians of the 18th century. Usually thought of as a novelist, Tobias Smollett was also a physician and, perhaps, the world's first proctologist.

Tobias Smollett has been rescued from the Victorian limbo by our increasing awareness of the tremendous vitality of the times in which he lived, and by the similarity of some of their problems to ours. Dr. Smollett was the predecessor of Melville, Conrad, and Monserrat. *Roderick Ransom* was the first realistic life of the common seaman. Smollett was a practicing physician, but his greatest talent was as a novelist. He was also a political satirist, pamphleteer, compiler, translator, playwright, and observant traveler. Some medical observations he made on pruritus ani have previously gone unnoticed, but I record them here as still pertinent and worthy of mention.

Tobias George Smollett was born into the gentry of Scotland. Fatherless and poor at an early age, through the help of relatives he received the classical education of his day. Bound over, at the age of 15, to a surgeon of Glasgow, he did not give himself completely to his new profession but began to write. This dichotomy was to be with him for almost the rest of his life.

During his apprenticeship he wrote a heroic play in blank verse, and at eighteen set forth to London, confident of its acceptance. Once there, he met with no success. The play was never produced and, even in later life, his first brain-child was given love, recognition and succor only by its father.

In order to eat he became a surgeon's mate on HMS *Cumberland* and sailed to the West Indies to take part in the prolonged, but unsuccessful seige of Carthagena (1741). While the decimated fleet lay over in Jamaica he met, wooed and married a planter's daughter, Anne Lessales. In London, with the help of his wife's dowry, he set up as a surgeon. He became good friends with many eminent medical figures of the day including Mead, Smellie and the Hunter brothers, John and William.

His medical services were not in such demand that he found no time to write. In 1748 *Roderick Ransom* was published and became a best seller. Thus at 27 he was not only a literary figure but a champion of the seaman's rights which eventually resulted in better working, sanitary, dietary, and medical conditions on British ships. During the next decade, he found himself intermittently practicing medicine, writing novels, editing and translating. He lived well and was generous to the needy so that his coffers were frequently empty. This may explain his frenetic activity.

Then with pulmonic complaints of some seriousness, he left for the Continent. The letters he sent to his friends in England were

gathered together on his return and published in 1766 as *Travels Through France and Italy*. Even today they are enjoyable and the eye of the trained physician is evident as he noted the lack of hygiene in the villages, the vermin in the inns, the variability of potable water. He was the sociologist as he commented on the difference between French and English attitudes towards the bodily functions of excretion, still present today. Smollett died in Leghorn in 1771 at the age of 50.

EVIDENCE as to the cause of death is rather meager: a cough, asthmatic at times, intermittent fever, some wasting, frequent anorexia. (His only daughter died of tuberculosis at the age of fifteen.) An intuitive diagnosis would be bronchiectasis, pulmonary tuberculosis, with miliary tuberculosis as the terminal event.

Whether he or his family had any anal difficulties, I cannot say, but in the writings of the latter part of his life Dr. Toby has some learned comments to make about hemorrhoids and pruritus ani. Of the latter . . . "This experienced leech, having prescribed a course of cathartics, balsamics, and sweetners, on the supposition that the blood was tainted with a scorbutical itch, at length found reason to believe that the disease was local. He therefore tried the method of gentle friction; for which purpose he used almost the very same substances which were many centuries after applied by Gargantua to his own posteriors; such as a night cap, a pillow bier, a slipper, a poke, a pannier, a beaver, a hen, a cock, a chicken, a calf skin, a hare skin, a pigeon, a cormorant, a lawyer's bag, a lamprey, a coif, a lure, nay, even a goose's neck. Nothing gave as much respite from this tormenting titillation as did smearing the parts with thick cream which was afterwards licked by the rough tongue of a bear-cat. In the meantime the distemper became so troublesome that the unfortunate man was incessantly in the fidgets, and ran around distracted, cackling like a hen in labour." The veritable legerdemain of modern treatment of pruritus ani contains some methods not far removed from Smollett's sarcastic account, an attack, by the way, on the prominent political figures of his day modeled after Swift's *Gulliver's Travels*.

Of hemorrhoids, he writes . . "Now kicking and cuffing were counted infamous among the French for these reasons: a box on the ear destroys the whole economy of their frisure, upon which they bestow the greater part of their time and attention; and a kick on the breech is attended with great pain and danger, as they are generally subject to the piles. This is so truly the case that they have no less than two saints to patronize and protect the individuals afflicted with this disease. One is St. Fiacre, a native of Ireland. He presides over the blind piles. The other is a female saint, Haemorrhoissa, and she comforts those distressed with the bleeding piles."

Smollett wrote only one medical paper, a treatise "On the External Use of Water," which advocated hydrotherapy for internal diseases. Didn't Osler advise the same for typhoid fever? He was aware of psychosomatic medicine for in *Humphrey Clinker* he describes such an episode very clearly. Smollett laid no claim to medical fame, although he did introduce the word "douche" into the English language.

2990 Alabama Road

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Trustees' Meetings

April 27, 1957

At its April 27 session, our Board of Trustees:

—Agreed to call a round-table conference of persons interested in the status of hospital radiologists, anesthesiologists and pathologists. The Chair named Dr. Schaaf, Dr. Bowers and Dr. Butler to sit with Mr. Nevin to draft a statement of our Society's position. The statement, as drafted by this special committee and approved by the Board is:

1. The services of the four groups* are specialties of the practice of medicine.

2. They should be paid for by Blue Shield, not Blue Cross.

3. The services of these specialists* should be separately billed for and should not be included as part of a hospital bill.

The Board also adopted the following recommendation:

The Board of Trustees recommends that the House of Delegates authorize it to convoke such general meeting or meetings as have been described, inviting the specialty societies concerned, the Hospital Association, Medical-Surgical Plan, and Hospital Service Plan to send duly accredited representatives.

—Directed that there be included in the Board's supplemental report to the House, a communication from the Monmouth Memorial Hospital, urging physicians to discourage purely diagnostic admissions for Blue Cross subscribers, and further urging that attending physicians refrain from ordering diagnostic procedures not related to the conditions under treatment.

—Ordered submitted to the House a report prepared by Dr. Featherston and his Committee on False Complaints.

—Approved in principle the establishment of an Advisory Council to the State Department of Health in reference to civil defense and disaster control.

—Referred to the Subcommittee on Public Health a proposed Organizational Code for Hearing and Speech Centers.

—Adopted a resolution indicating that the "routine health examination form" is not to be construed as the only method, or as a minimum method of examination.

—Accepted an invitation from Radio Station WTTM to participate with representatives of organized labor in a radio program, subject to obtaining further details about an acceptable date and data about the sphere of concern of the program.

—Approved the allotment of $128 to the Blood Bank Commission for stenographic transcript and secretarial work in connection with its seminar last fall.

—Agreed to cooperate with the State Department of Health in its current survey of the supply of poliomyelitis vaccine.

—Referred to the Committee on Revision of the Constitution, a proposal to amend Article VI of the By-Laws to add that: "Any member of this Society, not already a Fellow, who is elected President of the American Medical Association, shall at the completion of his term, become a Fellow of this Society."

—Approved proposed revisions in the Veterans Administration fee schedule with reference to psychiatric and neurologic services.

—Adopted a resolution of appreciation and thanks to Dr. Fritts, Dr. Murray, Dr. Blaisdell and Dr. Butler.

*Anesthesiologists, physiatrists, pathologists and radiologists.

April 30, 1957

At its reorganization meeting on April 30, 1957, the Board:

—Elected Dr. Carl N. Ware chairman of the Board.

—Elected Dr. Louis S. Wegryn secretary of the Board.

—Elected Dr. L. S. Sica to the Finance and Budget Committee.

—Reappointed salaried personnel in the Executive and Editorial offices at the salaries provided in the 1957-8 budget.

—Voted to abolish the position of Medical Director, Distribution of Medical Care.

—Reappointed Mr. Backes as Counsel to the Society at the fee provided in the budget.

—Reappointed Mr. Mincher as Legislative Analyst at the salary provided in the budget.

—Agreed to meet monthly during the 1957-8 fiscal year on Sundays selected by the President.

—Authorized the President to cancel a scheduled Board meeting if there was insufficient business to warrant the session.

Malpractice Insurance Problems

The following resolution originating with the Hudson County Medical Society was adopted in May 1957 by our House of Delegates. If you have malpractice insurance problems, you may communicate with the Medical Defense Committee through the Executive Offices of The Medical Society of New Jersey, 315 West State Street, Trenton.

Whereas, there continue to arise within the membership of the Society, problems of diverse nature concerning professional liability insurance—not the least of which involve excessive cost of coverage, particularly in instances wherein a claim against the physician is on record; therefore be it

Resolved, that The Medical Society of New Jersey be requested to investigate the plight of those members who—having been involved in litigation with reference to professional liability—thereafter find it impossible to obtain proper coverage except at excessively high rates.

Teen Age Gonorrhea is Increasing

The following item comes to us from the Bureau of Venereal Disease Control in our State Health Department:

Gonorrhea increased among young people in New Jersey during 1956. On the national level, teen-age venereal disease increased in eleven states. Of the 3,828 resident civilians reported with gonorrhea in New Jersey last year, 51 per cent were in the age group 10 to 24. This proportion during 1955 was 44 per cent. The increase during 1956 is statistically significant. Another noteworthy observation is the increase in gonorrhea in the 10 to 19 year age group. In 1955, 14 per cent of gonorrhea cases among civilians were 10 to 19 years of age and in 1956, 16 per cent were in this age group. This means that a greater proportion of individuals was infected with gonorrhea at a younger age than before.

The gonorrhea incidence rate, age specific, for the estimated population 20 to 24 years of age was 359 per 100,000 in New Jersey during 1956. One case of gonorrhea was actually reported for every 278 individuals in this age group.

On the basis of informed professional opinion it can be estimated conservatively that at least one of every 100 individuals in the age group 20 to 24 actually acquired gonorrhea during 1956 in this state.

Announcements • • •

New Seton Hall Appointments

Dean Charles L. Brown of the Seton Hall College of Medicine and Dentistry announces the designation of Desmond D. Bonnycastle, M.D., as professor and director of the Department of Pharmacology. Until this year, Dr. Bonnycastle was Assistant Professor of Pharmacology at Yale. Dean Brown also announces that Hugh G. Grady, M.D., has been named director of pathology and professor in that department. Dr. Grady until this year was Associate Professor of Pathology at his alma mater, the Jefferson Medical College.

Pediatric Allergy Course

A once-a-week, all-day course in pediatric allergy will be available every Wednesday, 9 a.m. to 4 p.m. at Flower-and-Fifth Avenue Hospitals in New York City. Under the direction of Dr. Bret Ratner, the course starts on November 6, 1957 and runs for 30 Wednesdays thereafter. Tuition fee is $300. For details, write to Postgraduate Dean, New York Medical College, 106th Street at Fifth Avenue, New York (29) N. Y.

Gastro-Enterology Course

Can you spend 3 days in Boston? If so, you can take the intensive gastro-enterology course to be given there October 24, 25 and 26 this year. Dr. Owen Wangensteen directs this program, while Dr. I. Snapper will direct the surgical part of the course. For details, write to American College of Gastro-Enterology at 33 West 60 Street, New York (23) N. Y.

$350 Medical Essay Award

A cash prize of $350 awaits the writer of the best paper on the application of our knowledge of hormonal relationships in carcinoma. This is the Caleb Fiske Prize of the Rhode Island Medical Society. It is the nation's oldest medical essay contest. Deadline is next New Year's eve. For details, write to Rhode Island Medical Society at 106 Francis Street, Providence 3, R. I. Indicate your interest in the Caleb Fiske Award.

Urology Award

The American Urologic Association announces an award of $500 (with a second prize of $300 and a third prize of $200) for essays on urology. Competition is limited to residents, interns and to urologists who have been out of medical school less than ten years. Details are obtained from American Urologic Association, 1120 North Charles Street, Baltimore, Maryland. Deadline for submission of papers is December 1, 1957.

Gynecology-Obstetrics Award

The International College of Surgeons has set aside, $800 for two awards for the best manuscripts (not more than 5000 words) submitted before December 1, 1957. Only alumni of accredited medical schools are eligible to participate, and then only if they are interns, residents, or teachers of obstetrics and/or gynecology. For full details, write to Dr. Harvey A. Gollin, 55 East Washington Street, Chicago 2, Illinois.

County Society Reports . . .

Atlantic County

The regular meeting of the *Medical Society of Atlantic County* was held April 12 at 9 p.m. at the Children's Seashore House. The president, Dr. Timberlake, presided.

Dr. Max Gross, speaking for the Chest Committee, urged cooperation in the June chest x-ray survey pointing out that ours was a high tuberculosis area.

The Society instructed its nominating delegate to support Dr. Jesse McCall for second vice-president of The Medical Society of New Jersey at the May meeting.

Dr. Rulon N. Rawson, Professor of Medicine at Cornell, delivered an interesting and practical paper on hyperthyroidism. Many members of the Society took part in the discussion.

A letter was read from The American Medical Society of Vienna thanking the Medical Society of Atlantic County for the donation of $100 given to assist Hungarian refugee doctors.

A letter was read from the Atlantic-Cape May County Pharmaceutical Association inviting us to be their guests at a dance to be held at the President Hotel on April 27.

A letter and application blank from Robert W. Datson, M.D., applying for Associate Membership was referred to the Censorship Committee.

A letter was read from Mabel H. Shonley, who expressed her appreciation for the interest and courteous cooperation during the fourteen years that she had been Executive Director of the Atlantic Visiting Nurse and Tuberculosis Association. She hopes that this fine professional relationship will be continued and extended to the next Executive Director.

A letter from the American Cancer Society of the New Jersey Division asked for a generous contribution from each of our members to the 1957 Cancer Campaign.

Dr. Timberlake announced the following new committees.

Finance Committee—Walter Stewart, Chairman, Harrison Nickman, Peter Marvel, Samuel Diskan, Morton Leach.

Nominating Committee—V. Earl Johnson, Chairman, Robinson Harley, Charles Hyman, Peter Marvel, Louis Rosenberg.

Dr. Molitch made the suggestion that the *Bulletin* publish a complete list of those members registering at the State Convention.

LEONARD B. ERBER, M.D.

Reporter

Bergen

The annual meeting of the *Bergen County Medical Society* was called to order at Bergen Pines County Hospital, Paramus, by William T. Knight, M.D., President, with 97 members present.

Elected to Associate Membership was Joseph James Territo; to Courtesy, Stuart Wilson McLeod; Dr. Joseph F. DeCotiis was granted a leave of absence to serve a residency.

A revised constitution was unanimously adopted after having been read at the two previous regular meetings and mailed to each member of the Society prior to the Annual Meeting. Revised By-Laws incorporating the creation of a Board of Trustees, new obligations of Associate members for service on Emergency Call Panels and attendance at meetings, clarification of succession to vacancies in society office and chairmanship of the Judicial Committee; and elimination of reference to the now defunct District Judicial Council was unanimously adopted after following the same procedure.

Members were given an interim report on the status of the survey regarding the possible addition of a Blue Shield group contract to the present Blue Cross group coverage.

A report from the Building Committee indicated considerable interest in a property located in the center of the county, which might be suitable as a location for a Society-owned building headquarters.

Elected to office for the fiscal year 1957-58 were the following: President, Dr. Leo J. Fitzpatriek; First Vice-President, Dr. George Heller; Second Vice-President, Dr. Donald B. Hull; Secretary and Reporter, Dr. Charles P. Campbell; Treasurer, Dr. Frederiek L. Muller; Assistant Treasurer, Dr. John P. O'Connor; Members of the Judicial Committee, to fill the unexpired one-year term of Dr. Paul Liva, Dr. LeRoy Black; for the regular five-year term, Dr. Winton H. Johnson.

The scientific session was devoted to a discussion led by a panel consisting of the outgoing officers, the new officers and Mr. Richard L. Nevin, Executive Officer, The Medical Society of New Jersey. During this discussion, plans were proposed which were hoped would increase attendance at meetings during the coming year, closer rapport between the State Society and this Society was suggested and members were given the opportunity of offering constructive criticism of any of the Society's activities or policies.

CHARLES P. CAMPBELL, M.D.

Reporter

Middlesex

The sun shone brightly upon the Forsgate Country Club on Wednesday, May 8, as the Annual Social Outing of the *Middlesex County Medical Society* convened. Twenty-six members enjoyed the afternoon on the links. At 7:15 p.m. we sat down to a sumptuous steak dinner followed by a timely and interesting talk by Mr. Edward Patton, Secretary of State of New Jersey. In view of the attendance (35 members for dinner) it was decided not to transact any business.

The meeting was formally adjourned at 9:30 p.m.

MORTON M. KLEIN, M.D.

Reporter

Monmouth

Monmouth County Medical Society held its regular meeting on May 22 at Monmouth Memorial Hospital, with Dr. John Hardy presiding.

Dr. Jerald R. Cureton, Eatontown, was elected to associate membership. Military courtesy membership was extended to the following medical officers of Fort Monmouth: Colonel Rollin L. Bauchspies; Lieutenant Colonels Bruce D. Storrs, Gennady E. Platoff, and Lawrence W. Greene; Major Henry T. Zelechosky, and Captains Norman E. Rubinstein, George W. Girvin, Stephen M. Ayres, Gerard A. Levi, James S. Quinn, Carl S. Ross, Neal L. Ross, Joseph W. Schauer.

The scientific session featured Dr. Walter Lawrence, Jr., of the Memorial Hospital, New York City. Dr. Lawrence presented a statistical analysis of 1623 patients treated for gastric cancer at Memorial Hospital over the past twenty years.

DONALD W. BOWNE, M.D.

Reporter

Passaic

The annual meeting of the *Passaic County Medical Society* was held on May 21 at 9:00 p.m. at the Medical Society Building. The meeting was presided over by Dr. Abraham Shulman, President.

Resolutions were read on the death of two members, Dr. Harry Newport Golding and Dr. Ernest E. Johnson. Both resolutions were adopted as read.

Dr. Shulman read the names of thirteen members of our Society to whom were bestowed the Golden Merit Award by The Medical Society of New Jersey, to honor those who have completed fifty years of practice. Three were present to receive the awards in person.

The President reminded the members of the A.M.A. dues payment before the Annual Meeting in June. He also urged them to send in their biographic sketches required by The Medical Society of New Jersey.

The following officers were elected for 1957-1958:

President—Samuel C. Yachnin, M.D.
First Vice-President—Theodore K. Graham, M.D.
Second Vice-President—Julian Cohen, M.D.
Secretary—Joseph F. Moriarty, M.D.
Treasurer—Frank B. Vanderbeek, M.D.
Reporter—David B. Levine, M.D.

The President then expressed his appreciation to the officers and members for their cooperation and interest in the activities of the Society during his administration, and extended his good wishes to the new president, Dr. Samuel C. Yachnin.

Dr. Shulman then turned the meeting over to Dr. Frank B. Brogan who introduced the speaker, Henry A. Brodkin, M.D., Medical Director of New Jersey's Department of Labor and Industry. Dr. Brodkin's topic was "The Doctor and the Injured Worker." This was followed by a question period.

At the close of the program a collation was served by Mrs. Sidney Brooks, Chairman of the Hospitality Committee of the Woman's Auxiliary. An abundance of spring flowers from her garden attractively decked the tables.

DAVID B. LEVINE, M.D.

Reporter

Salem

The annual meeting and shad dinner of the *Salem County Medical Society* was held Saturday afternoon, May 18, at the Salem Country Club. After the dinner, President Isadore Lipkin introduced the society's guests, which included Dr. and Mrs. Lewis C. Fritts of Somerville, President of The Medical Society of New Jersey in 1956-57; Dr. and Mrs. Albert B. Kump of Bridgeton, President for 1957-58; Mr. and Mrs. Richard I. Nevin of Trenton, Executive Officer of The Medical Society of New Jersey; and Mr. and Mrs. Joseph Colson of Woodstown.

Dr. Lipkin also introduced the county society's new officers and then turned the meeting over to the president-elect, Dr. W. Garrett Hume of Woodstown, who introduced the evening's speaker, Mr. David Meharg, Special Consultant to the Medical Department of E. I. du Pont de Nemours. Mr. Meharg told of his work with the problem of alcoholism in a talk entitled *How to Enjoy Drinking Longer*.

W. L. SPROUT, M.D.

Reporter

N. J. Dermatologic Society

At the May 20 meeting of the New Jersey Dermatologic Society, the following members were elected as officers for 1957-58:

President: Seymour L. Hanfling, M.D., of East Orange.

Vice-President: Benjamin B. Burrill, M.D., of Montclair.

The following were re-elected:

Secretary: John R. Tobey, M.D., of Newark

Treasurer: Samuel Fisher, M.D., of Paterson

All communications should be addressed to the secretary, John R. Tobey, M.D., 11 Hazelwood Avenue, Newark.

JOHN R. TOBEY, M.D.

Secretary

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

The Changing Patient-Doctor Relationship. Martin G. Vorhaus, M.D. New York 1957. The Horizon Press. Pp. 311. With cartoons by A. Birnbaum. ($3.95)

The frustration cycle in doctor-patient relationships is well known though little spoken of. The doctor fails to communicate somehow, and the patient feels misunderstood. He becomes hostile to doctors, may visit cultists who do fulfill his psychological needs. And then he gets sick and hopefully starts over again with a new doctor. In addition to clinical acumen in the traditional sense, the doctor needs to understand what disease "means" to a patient psychologically. Furthermore, if the patient fails to grasp the physician's meaning, chances are that he (the patient) will not say so—thus erecting a complete barrier to communication.

Vorhaus shows the need for developing expertise in the handling of words—after all this is the major physician-patient communication channel. He also shows the poignancy of communication by pantomime. The book is written in a smooth style, salted with many examples of word usage and numerous brief case studies. There are also several detailed case reports showing the analytically oriented psychotherapy done by the author—who is an internist, not a psychiatrist. These reports are well done, with large verbatim conversational fragments. Mr. Birnbaum's witty cartoons add a third dimension to this unusual book. The text makes psychosomatics a living specialty. The book provides much food for thought—and for staff room conversation, too. It is a solid $3.95 worth and its precepts are practical.

ABRAHAM LEFF, M.D.

Atomic Energy for Medical Officers. By the staff of the (British) Royal Naval Medical School. Pp. 169. New York 1957. Philosophical Library. ($4.50)

If you don't mind spending $4.50 for a slim, pocket-sized volume, you will find here a solid primer of atomic energy. The anonymous authors review in clear language the essentials of atomic structure, natural and synthetic radioactivity, properties of fission, and the life history of the cell. There is a discussion of the medical hazards of radiation and a prognostic guide to atomic casualties. Treatment, however, is dismissed in only two pages. Perhaps that is all that is known about the subject. The chapter on protection and decontamination is compact and useful. The book concludes with six appendices and a bibliography.

ULYSSES FRANK, M.D.

Battle for the Mind. William Sargant, M.D. Garden City, 1957. Doubleday. Pp. 263. ($4.50)

Politicians, policemen, psychiatrists and evangelists are all interested in changing people's viewpoints—and in effecting a basic emotional conversion, not simply a mechanical repetition of words. The technic is called education if you approve of the goal, indoctrination if you are skeptical of it and brain-washing if you don't like it. In this book, Dr. Sargant tries to explain the phenomenon in terms of reconditioned reflexes. He is belligerently hostile towards psychoanalysis, so that he rejects any psychoanalytic explanation of the process. There are some very good studies here of brain-washing technics in action, and Dr. Sargant ranges

the world of space and time from Wesley in the 18th century to Stalin in the 20th, from religious snake handlers in the American south to doomed prisoners in London's Newgate.

What to do when threatened with brain washing? "The obstacles that the proselytizer cannot overcome" says Dr. Sargant, "are indifference and amusement on the part of the subject. The safety of the free world therefore seems to lie in a cultivation, not only of courage, moral virtue and logic, but of humor." Humor, indeed! Apparently the author was never subject to the gentle interrogations of a secret police inquisitor.

HERBERT BOEHM, M.D.

Clinical Management of Varicose Veins. By David Woolwolk Barrow, M.D., New York. Paul B. Hoeber. Ed. 2, 1957, 169 pages. ($6.00)

The development of peripheral vascular disease therapy as a distinct medical and surgical specialty has created a new interest in the care of the venous as well as the arterial side of the circulation. Great strides are being made in the diagnosis and treatment of many vascular diseases. The treatment of varicose veins has shared in this resurgence of interest. However, there is, so to speak, a consistent anatomic inconsistency in the distribution of the superficial veins of the extremities. This new edition of Barrow's book capably describes and illustrates the great variety of superficial venous distributions and describes their role in the formation and recurrence of varicose veins of the legs.

The multiplicity of procedures, both medical and surgical, for varicose veins is a reflection of the unsatisfactory state of such therapy. A better understanding of these problems may be obtained by carefully reading this monograph. The book as a whole is excellent. Its value as a guide would be improved by the omission of such non-specific statements as "—therapy *may* be very helpful here." The deletion of many of the specific case histories and the inclusion of more colored photographs would enhance the book's value.

This new second edition of Dr. Barrow's monograph on varicose veins is recommended reading for all physicians interested in the management of varicose veins alone, and/or their associated complications.

JACOB SCHMIDLER, M.D.

Medical Services for Rural Areas. Willman A. Massie. Cambridge, 1957. Commonwealth Fund and Harvard University Press. Paper Pp. 68 ($1.25)

Following a survey by its subsidiary foundation, the Tennessee Medical Society set about remedying the deplorable lack of medical care in a northeastern section of Tennessee where deprivation and primitive living beggar description. Its first and most spectacular project was Pruden Valley. Told are how needs were recognized and defined, resources inventoried, plans formulated and implemented: how the support of a better-known foundation, medical educators, public health facilities, labor unions, local officials, civic groups, the church, the school were enlisted. The course of the project is related and evaluated.

Not just another hackneyed story of a welfare project, this is an inspiring and definitive account of medicine in its best tradition forwarding the health, economic welfare and cultural life of the people. One may in truth observe that not all Pruden Valleys are in Tennessee and, too, that devotees of Albert Schweitzer might well emulate him right here in America.

JOSEPH G. SUTTON, M.D.

A Visit to the Hospital. By Francine Chase. Prepared under the supervision of Lester L. Coleman, M.D. Introduction by H. Flanders Dunbar, M.D. New York, 1957. Pp. 68. ($1.50)

Even though my daddy is a doctor, I still wondered how it would be when I had my tonsils out. So daddy let me read this book. There was a picture on every page. The print was big and the words were just the right size for a girl in third grade to read without asking grown-ups what some of the words meant. The book told about going to a hospital and what would happen and after I read the book I knew what to expect. And it was just like that too and I'm glad I had the book to read. I think all boys and girls who can should read this book before they go to any hospital. And if they can't read, I think the boy or girl should sit on daddy's lap or mommy's lap and have the book read out loud. He won't be scared about the hospital if he reads this book first. That's what I think.

ELLEN MAY DAVIDSON

The Treatment of Burns. Curtis P. Artz, M.D. and Eric Reiss, M.D. Saunders, 1957, Philadelphia. Pp. 250. ($7.50)

If you do not mind paying $7.50 for a 250 page book, you will find here a profusely illustrated, practical manual which covers every aspect of the care of burns. There are chapters on immediate and subsequent care; on the scope of the problem; on the emotional aspects; on the prevention of infection. There is discussion of such practical points as how to turn a patient in bed. There is even a chapter on management of burns in large scale disaster. The illustrations really illustrate. Altogether, one of the most practical books on burns ever published.

VICTOR HUBERMAN, M.D.

TUBERCULOSIS *Abstracts*

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXX July, 1957 No. 7

Tuberculosis Organisms Resistant to Drugs

By. John L. Gompertz, M.D., and Donald E. Porter, California Medicine, December, 1956.

Improved surgical techniques, modern drug therapy and an increasing trend toward home care have resulted in a pronounced shortening of the hospital stay of patients with tuberculosis.

Persons who have had this disease are living longer and this increased length of life and the care of the patients at home plus drug therapy which nearly all patients receive, have created problems of their own. Two of these were made the subject of a study, sponsored by the California Tuberculosis and Health Association, namely: The incidence of hospitalized patients in whom the tubercle bacilli are resistant to anti-tuberculosis drugs on first admission; and the rate of relapse among tuberculous patients who have been discharged previously from any tuberculosis hospital.

PLAN OF STUDY

A questionnaire requesting information concerning admissions, discharges, evidence of drug-resistant organisms in sputum, and relapse rates was sent to 15 tuberculosis hospitals with 4,121 beds among the state's approximately 11,500 beds for tuberculosis. To obtain a valid sample, a small research hospital, a large county hospital, a group of medium sized county sanatoriums and a private hospital were included.

Four specific questions were included in the questionnaire. They were:

1. What is the incidence of patients who have left your hospital for any reason whatever and who have a positive sputum?
2. What is the incidence of patients *discharged* with positive sputum whose sputum possesses organisms resistant to one of the anti-tuberculosis drugs and to which drug(s)?
3. What is the incidence of patients *admitted* to your hospital for the first time with positive sputum, whose organisms are found to be drug-resistant to one or more anti-tuberculosis drugs, and to which drug(s)?
4. What is the percentage of patients admitted to your hospital after having once been discharged from any institution as inactive?

An early inquiry here indicated that no nation-wide data are available on relapse rate or on sputum status of patients admitted to hospitals.

However, in 1955 Chaves and co-workers reported on 898 patients observed by physicians in the New York City Department of Health for a period of 18 months. M. tuberculosis was demonstrated by culture of the specimens of 385 patients. Of the 43 patients (11 per cent) from whom strains were isolated which showed any resistance to streptomycin or isoniazid, only 15 (3.9 per cent) were significantly resistant. These 15 made up 1.7 per cent of the series of 898.

Beck reported ten cases of pulmonary infection with drug-resistant tubercle bacilli in a five year study of 600 cases of newly diagnosed tuberculosis admitted to a New York State Tuberculosis Hospital. This is about 2 per cent of the 480 who had positive sputum, or 1.7 per cent of the 600 studied.

In our study among a total of 5,559 patients discharged from 15 institutions in 1954, 879 or 15.8 per cent had sputum positive for tubercle bacilli at the time of discharge. The lowest rate

INCIDENCE OF PATIENTS ADMITTED TO FOUR INSTITUTIONS WITH POSITIVE SPUTUM IN WHOM ORGANISMS WERE RESISTANT TO ONE OR MORE ANTITUBERCULOSIS DRUGS*

Institution Number	Total First Admission 1954	Total First Admissions, Positive Sputum and Drug Resistant	Per Cent Positive Sputum and Drug Resistant
3	377	45	11.9
5	160	15	9.4
7	67	17	25.4
13	158	12	7.6

* Includes all drugs.

for any of the 15 institutions was 1.9 per cent and the highest was 28.3 per cent. Many of the discharges were, of course against medical advice.

During the year 1954, the 15 institutions reported an average length of stay of 240.8 days, reflecting the trend toward a shorter hospital stay.

The table shows the number of sputum-positive patients admitted to four institutions who were found to be resistant to one or more of the anti-tuberculosis drugs. At the time of this study, only four of the fifteen institutions included reported that drug sensitivity tests were being conducted. For those four hospitals, the total number of patients admitted during 1954 was 762, of which 89 (11.7 per cent) had positive sputum with organisms resistant to one or more anti-tuberculosis drugs.

The four institutions reporting as having conducted drug sensitivity tests had a total of 762 first admissions during 1954. Of these patients, 13 (2.4 per cent) were found to be resistant to para-amino salicylic acid, 26 (3.4 per cent) to isoniazid and 34 (4.5 per cent) to streptomycin.

Thus 7.9 per cent of the total number of patients admitted were found significantly resistant to isoniazid or streptomycin. This is about four times the incidence reported by both Chaves and Beck (1.7 per cent of each total series studied).

Ten of the 15 institutions reporting submitted complete data relative to the number of patients admitted who had been discharged from any tuberculosis hospital previously with disease inactive. The rate of relapse among patients in these ten institutions in 1954, is approximately one of every five patients admitted.

These data are probably not (very) accurate as the patient's word was taken for the diagnosis at the time of previous discharge. Some patients may have been ignorant or forgetful, particularly those who left against medical advice.

Several interesting and significant facts came to light: In the 15 institutions reporting, the proportion of patients discharged with sputum positive for tubercle bacilli averaged 15.8 per cent. The range of 1.9 to 28.3 per cent was very wide and the disparity was unexplained. One might hazard the guess that those hospitals having the higher rates also had a high rate of patients signing out against medical advice.

Only four of the 15 institutions reported drug sensitivity tests of positive sputums on entry. No reliable data as to drug resistance could be found for patients who had a positive sputum at the time of discharge. Drug sensitivity studies are important in workmen's compensation cases and from a public health and treatment standpoint. More tuberculosis institutions should be encouraged to carry out drug sensitivity studies on sputum.

The importance of drug sensitivity studies on the bacilli of patients being considered for operation cannot be emphasized too strongly.

The significance of present drug resistance studies is not entirely clear, as there are differences of opinion regarding the pathogenicity of some drug-resistant bacilli.

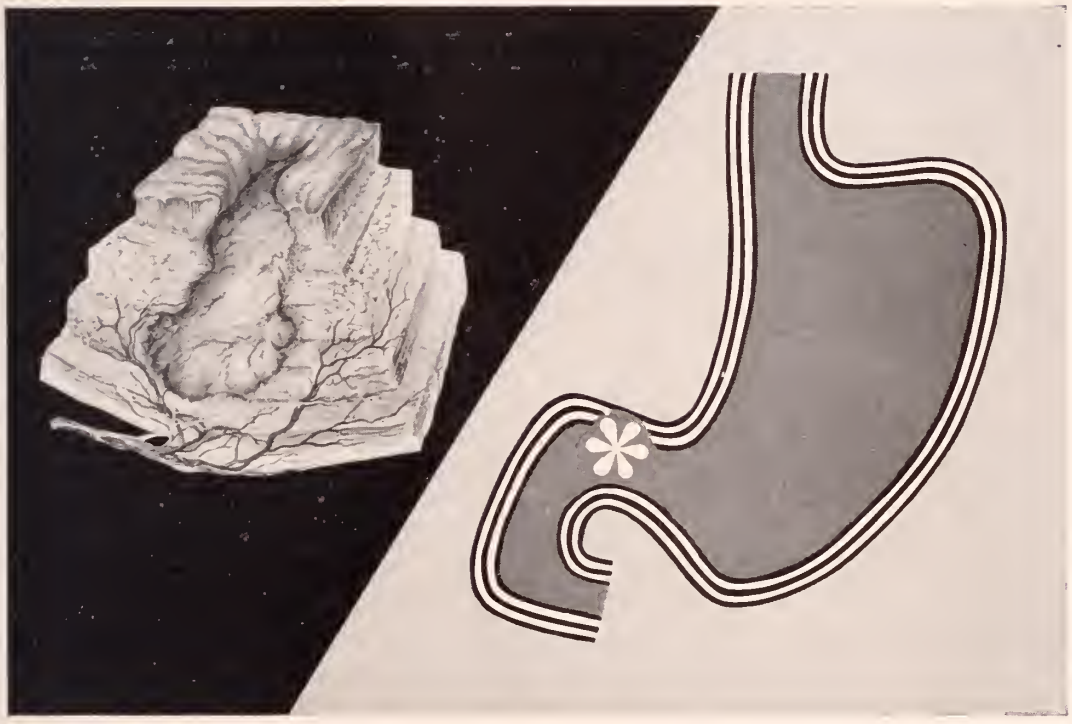
The probability is that as more drugs are used in treating tuberculosis, more resistant strains will be developed. Among patients admitted to the hospital for the first time whose sputum was positive for tubercle bacilli, 11.7 per cent had organisms resistant to one or more anti-tuberculosis drugs.

More research is necessary to ascertain the nature of resistant organisms, and to prevent resistance from occurring. Perhaps a way can be found to cause the bacilli to revert to a sensitive state.

The proportion of readmittances to tuberculosis hospitals is sizeable. Perhaps it should not be called a relapse rate, inasmuch as not enough is known about the facts behind previous admissions. In any case, an average readmittance rate of 19.2 per cent seems much higher than it should be.

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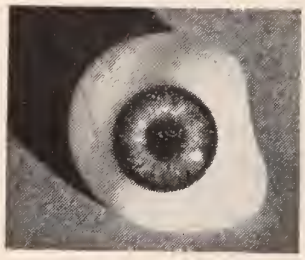
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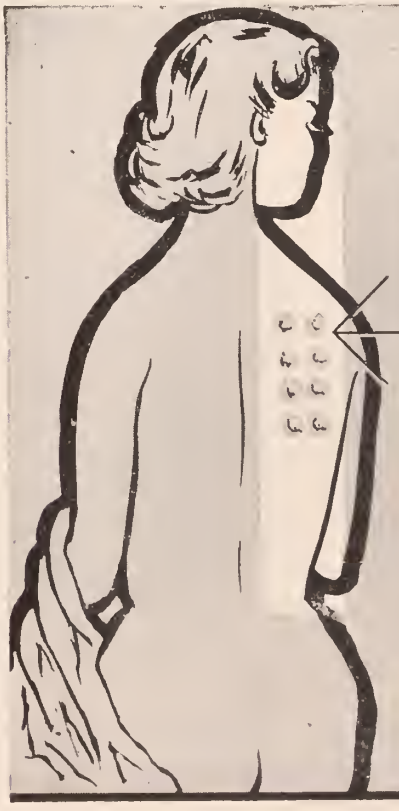
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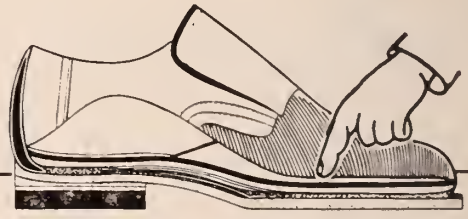
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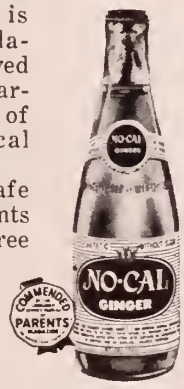


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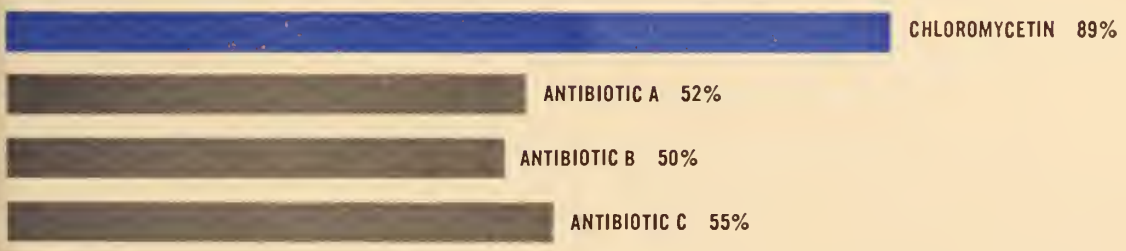
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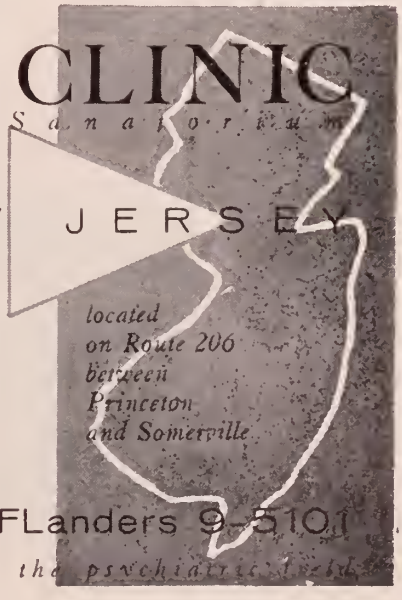
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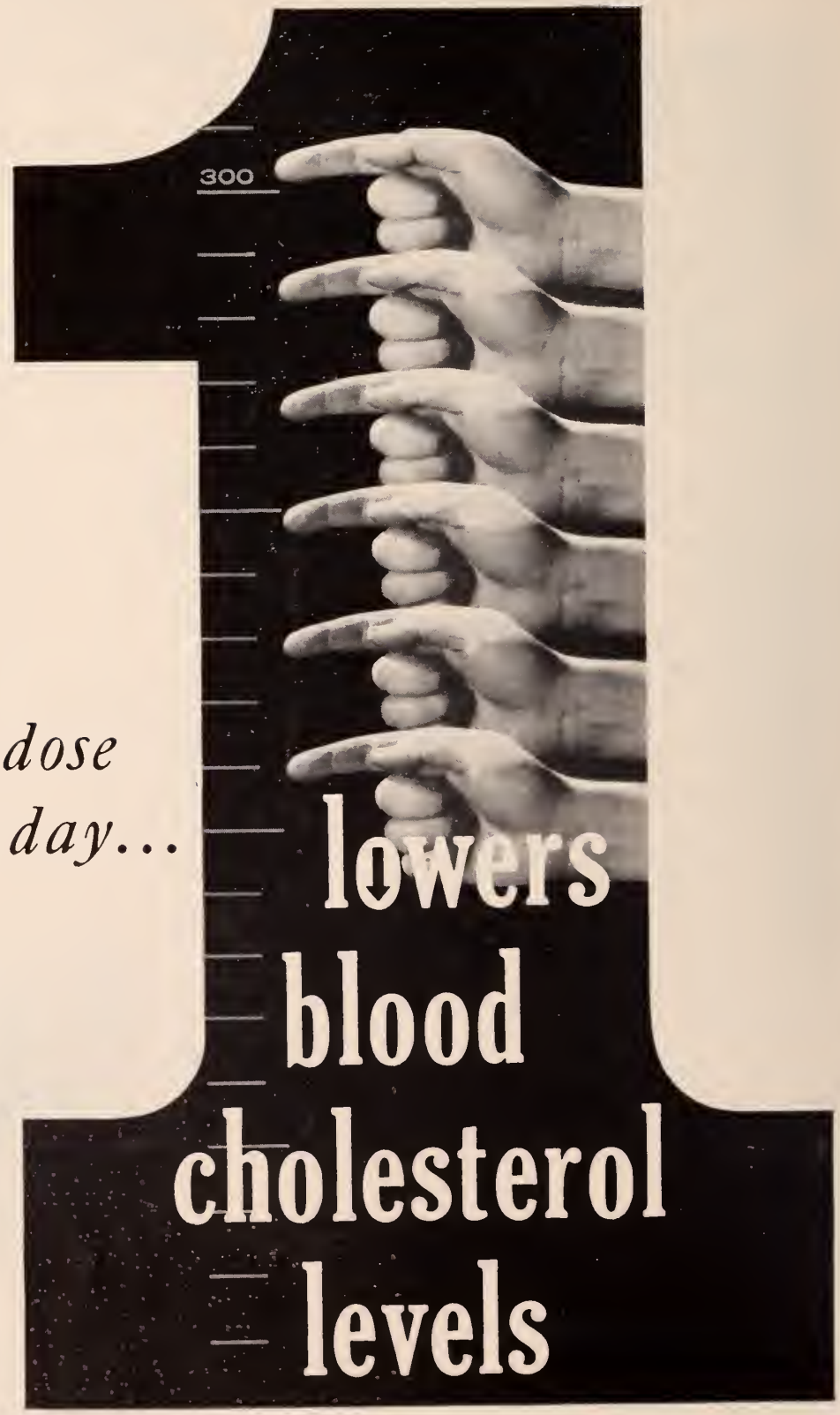
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References: 1. Borrus, J. C.: *M. Clin. North America,* In press, 1957. 2. Gillette, H. E.: *Internat. Rec. Med. & G. P. Clin.* 169:453, 1956. 3. Pennington, V. M.: *J.A.M.A.,* In press, 1957. 4. Cayer, D.: Prolonged Anticholinergic Therapy of Duodenal Ulcer. Am. J. Dig. Dis. 1:301-309 (July) 1956. 5. McGlone, F. B.: Personal Communication to Lederle Laboratories. 6. Texter, E. C., Jr.: Personal Communication to Lederle Laboratories. 7. Bauer, H. G. and McGavack, T. H.: Personal Communication to Lederle Laboratories.

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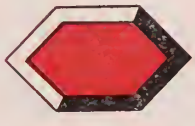
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References: 1. Communication to Abbott Laboratories, 1956. 2. Moyer, J. H. et al: Deserpidine for the Treatment of Hypertension. Southern Medical J., 50:499, April, 1957.



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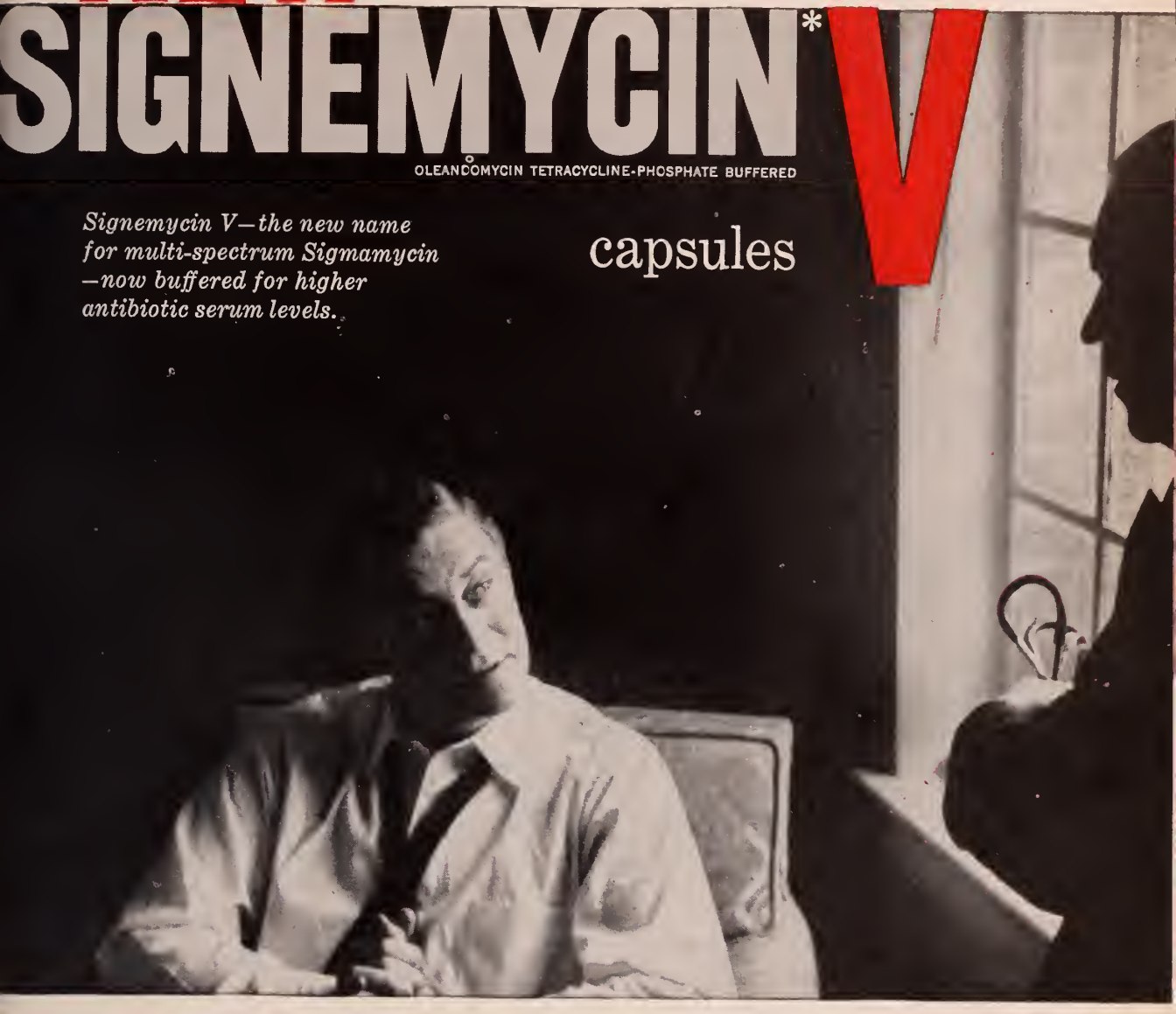
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Natural belladonna alkaloids: hyoscyamine sulfate (0.1037 mg.) atropine sulfate (0.0194 mg.) hyoscine hydrobromide (0.0065 mg.)	anti-spasmodic	Relieves intestinal hypermotility and hypertonicity.
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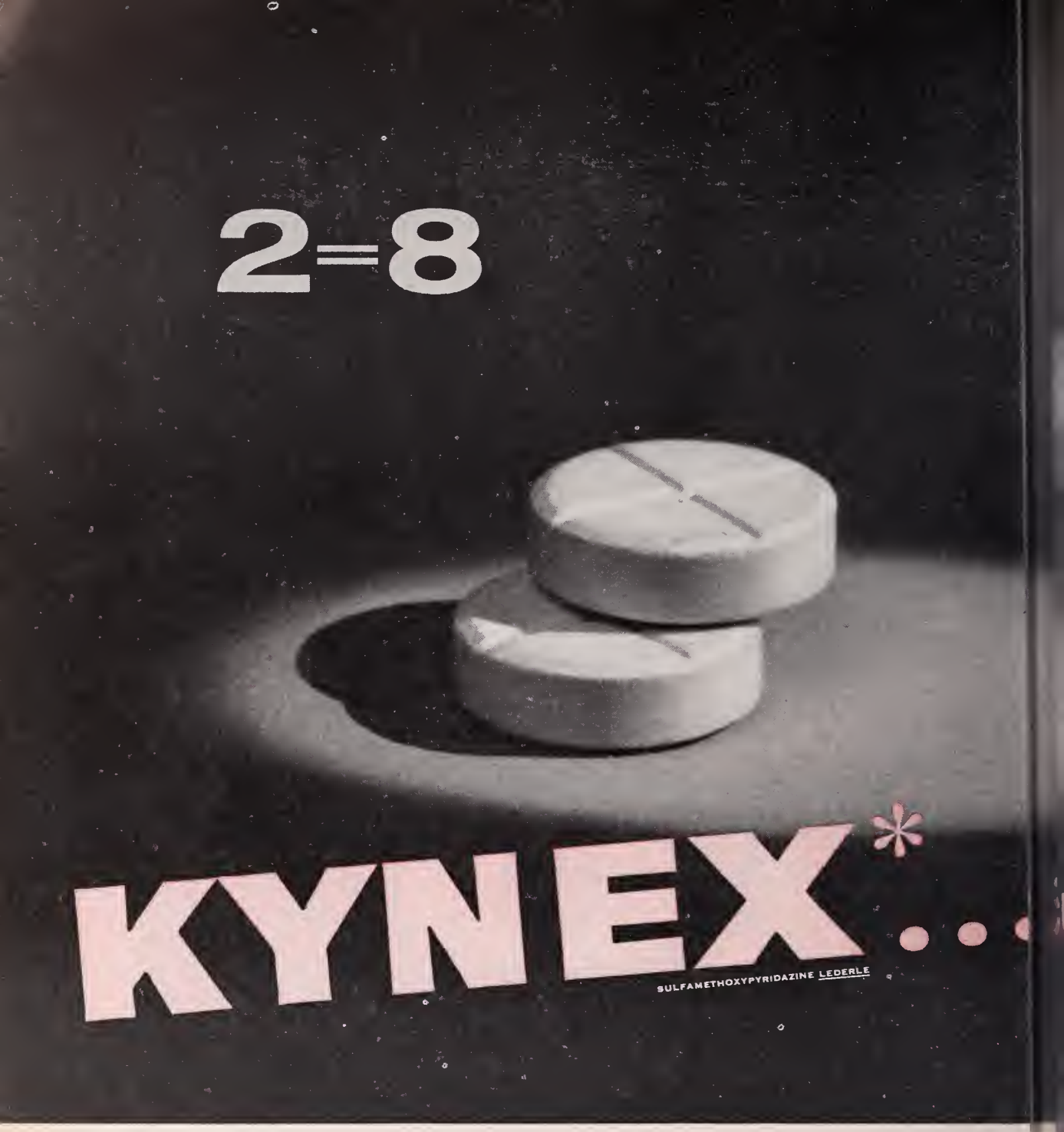
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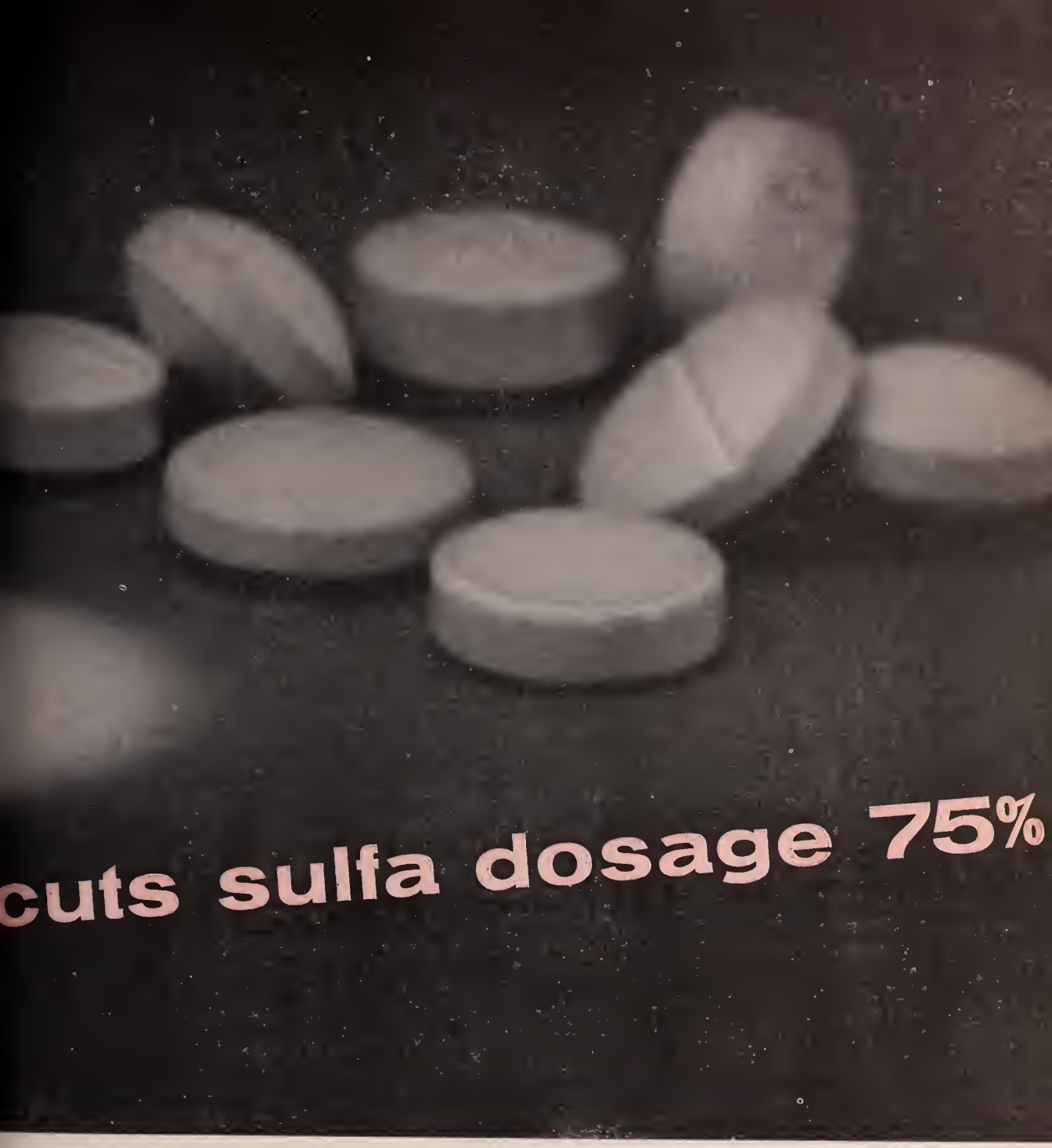
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(1) Boger, W. P.; Strickland, C. S. and Gylfe, J. M.: Antibiot. Med. & Clin. Ther. 3:378 (Nov.) 1956.

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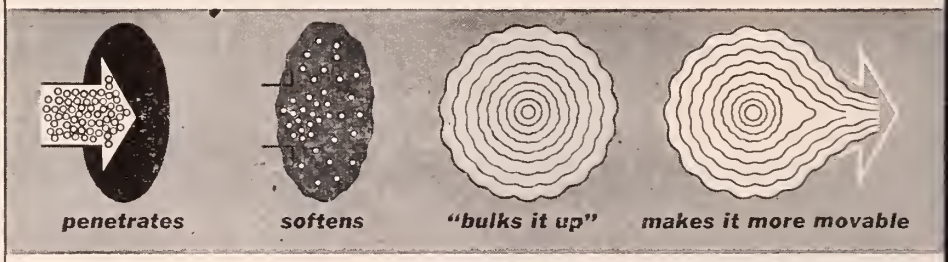


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Editorials • • •

The Doctor and His Nomenclature

It is fashionable to grumble about the Standard Nomenclature which the hospital record librarians want us to use. On the face of it, it looks as if the big red book is just so much big red tape. After all, you know what you mean when you say hypertension—why must you spell it out as hypertensive vascular, or hypertensive cardiovascular disease? And if you prefer to say Buerger's Disease why must you rewrite it as thromboangiitis obliterans? And those weird code numbers! 690-1x1.6! . . . why should anybody scrawl mystic figures like that after a diagnosis?

The question is fair enough, and it is not to the credit of the statisticians, record librarians and staff officers that they have failed to answer it. Why a standard nomenclature?

First, because we must talk a common language. Your concept of Paget's Disease may not be mine, and Addison's anemia is not the same as Addison's Disease. Erb's dystrophy is different from Erb's palsy, and we are not sure whether Meniere's Disease is the same as Meniere's syndrome. (But hydrops of the labyrinth, now, that's clear).

Then, too, medicine is too crowded to permit widespread use of eponyms. All honor to Alzheimer, Bright, Charcot and all the rest down the gallery of great names, from Addison to Wilson-Kimmelstiel. But a record must not look like a collection of tombstones in medicine's Hall of Fame. The eponym is inexact, ambiguous and not flexible enough to allow for new discoveries.

What difference does the "word" make? If the doctor simply locks the record in his cabinet, if no one ever sees it, if the diagnostic term never moves outside the doctor's office, then the word makes no difference. Whether the practitioner labels the condition as ooblock, Zilch's Syndrome, or Acute Nonsuppurative Cervicodynia, it's all the same so long as he treats the patient properly.

But charts do not stay locked in the file cabinet. The charts may stay there, but the words don't. More than half of your patients have some kind of health or hospital insurance, where your diagnosis is needed to process a claim. If your patient ever gets to a hospital, whether insured or not, there will be a request for your diagnosis. If he applies for

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life insurance, seeks to get into, or out of the Army, your label leaps into importance. If he dies, the words on the death certificate assume legal significance in terms of collecting on claims. Also, these death certificates are the basic building blocks of medical research. If he does not feel able to work, the city welfare department may insist on knowing the nature of his disability. If they don't care, Social Security does. If he does work, his labor union may have a "health benefit" in its contract and they want to know the diagnosis.

So your diagnostic term has wings. It also has immortality. You will die, but your writings won't. Forever and ever, some document signed by you or written by you, carrying a diagnosis, will lie in some hospital or insurance company file. If the diagnosis is bizarre, ambiguous or non-acceptable, there it remains silently branding you.

Then, too, this is the age of the business machine. Giant electric brains restlessly figure morbidity rates and insurance premiums. Into the maw of the statistical machine are poured the raw data of diagnoses. The machine, however, can do it only by the numbers. On the punch card, position is everything, and position is keyed to numerals, not concepts. So a standard nomenclature is needed to permit the keying of diagnoses to the machine.

The good old names are romantic. Milk leg and weeping ulcers are picturesque terms. Osgood-Schlatter sounds learned and the curt word "stroke" is dramatic. But this is the place for efficiency, for clean and crisp terms, not for romance and picturesqueness.

The standard nomenclature makes you think, and this is sometimes unpleasant. It's so easy to write "apoplexy." But if you have to decide whether this is a thrombosis or an embolism, whether it is in the lenticulostriate artery or the lenticulo-optic artery, then you have to think.

Standard terminologies are here to stay. The doctor who prefers the quaint old labels cannot change that. You aren't going to lick this drive towards a simple, standard, sharply focussed nomenclature. And if you can't lick them it would be better to join them.

Public Education and Infant Mortality

During the 1918 influenza epidemic, health officers throughout the state were giving newspaper interviews and suggesting tricks to ward off the "germ." (It was then thought to be due to the Pfeifer bacillus.) Here, in New Jersey, were the usual claims, predictions, warnings and preachings. One man, however, saw this epidemic essentially as a lesson in the need for health education rather than as a vehicle for specific pronouncements. He was Julius Levy, director of the child health section of the Newark Board of Health. He was hammering away then at the importance of communicating knowledge to the public. He is still hammering away at it. And he's right. In his own field, the infant death rate (per 1000 live births) has tailspinned from 102 to 26 since those World War I Days.

This year some 300,000 American babies will have a first birthday who would have died in infancy if they had been born forty years ago. Behind this dramatic improvement lie two major factors—medical progress and the *public's increasing willingness* to take advantage of this progress.

Many mothers have amply shown their interest in adequate prenatal care, deliveries in the hospital rather than the home, and preventive medical care for infants in physicians' offices and well-baby clinics.

More than 100,000 infants died last year. An authoritative study sponsored by the New York Academy of Medicine* indicated that more than half the early neonatal deaths in full-term deliveries might have been prevented by better health practices.

Although further strides will be made in future, the success of medical science will depend on better understanding and liaison be-

*Kohl, Schuyler, G., *Perinatal Mortality in New York City*, Harvard University Press, Cambridge, 1955.

tween hospitals and doctors on the one hand and the public on the other.

The causes of more than half the current total of fetal and early neonatal deaths are unknown or ill-defined. As a result, leaders stress the need for further research in the causes and prevention of infant deaths, as well as further gains in administrative relationships in hospitals, medical record-keeping and the exchange of technical knowledge.

Just as fundamentally, however, *further progress depends on communicating more adequately with the portion of the public that is not taking full advantage of existing knowledge* about maternity and infant care. Infant mortality rates are highest among the groups who show the least inclination to use modern medical services and modern health practices. However, there is latitude for improvement in all income groups—improvement which can come as modern knowledge is more broadly used by the public.

There is no easy answer to the question of how to make every group want to take advantage of modern medical facilities; some people may not be receptive to educational processes and still others have never really been exposed to them. But any substantial improvement in infant mortality must have impact on all groups if we are to bring the potentials of science to everyone.

The "Doctors' Plan"

Blue Shield was initiated by organized medicine, it is approved by the county and state societies, and its medical policies are determined by physicians. Hence, Blue Shield is the "doctors' plan." We like the phrase but there are always some cynics who think the "doctors' plan" is designed primarily to benefit the doctor, rather than the patient.

If the doctor fails to acknowledge Blue Shield as his own, if he declines to accept the responsibilities of a participating physician, or if he uses the Blue Shield payment merely as a platform upon which to charge a higher fee, then the public will conclude that Blue Shield is operated for the doctor's benefit.

But if the physician looks upon himself as the trustee of Blue Shield, if he speaks well of the Plan, if he tries to help his patients understand the plan and use it intelligently—then the patient will identify Blue Shield with the idealistic traditions of medicine.

Blue Shield *is* the "doctors' plan," not in the sense that the doctor owns it, but because he has organized it to help him serve his patients more satisfactorily. It is the "doctors' plan" because the doctor is responsible for it, and because Blue Shield is proof of the doctors' concern for the welfare of the people.

Blue Shield now serves the vital needs of more than 37 million Americans. Thirty-seven million Americans can't be wrong, and their support of this program represents a tremendous vote of confidence in the medical profession. Blue Shield is a bond of mutual benefit between the profession and the people.

Your Blue Shield Plan is yours — to strengthen and improve. Today, it is the medical profession's best answer to the challenge confronting the profession, to prove that we can solve our own problems by voluntary cooperation with industry, labor and the public. What Blue Shield may become is up to *you!*

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Newark

Operative and Non-Operative Lesions of the Heart*

A CLARIFICATION

In this veritable encyclopedia of cardiac surgery, the St. Michael's group discuss frankly indications, contra-indications and technics. The note of self-restraint is especially welcome in an area where unbridled enthusiasm can be perilous.

Advances in the surgical treatment of cardiovascular diseases have improved the prognosis of previously fatal congenital and acquired cardiac lesions. Crippling deformities and malformations of the heart now can be functionally reversed and improved. Such dramatic achievements have generated tremendous, and, at times, overwhelming enthusiasm. This had prompted the development of new and improved surgical technics. Some of the less discriminating enthusiasm, however, has resulted in confusion about the acceptability of certain surgical procedures. Since all cardiovascular lesions are not amenable to surgery, it is necessary to understand the scope and limitations of each operation.

The successful application of a given surgical technic is dependent upon an understanding of the underlying pathologic physiology and the natural history of the disease. All procedures before being applied clinically, first must have adequate research background and experimental study.

The surgeon must exercise self-discipline in the selection of technics that fall within the scope of his experience and the limits of the facilities available. Such restraint would materially avoid unnecessary and improper operations. Cardiac surgery should be done only by persons qualified by experience and training acquired at cardiac centers that are well equipped in experimental and clinical material. And a smoothly-working, well-trained team of competent physiologists, anesthesiologists and cardiologists should work in cooperation with the surgeon.

The concepts presented in this paper [1] are based upon observation of 5,456 patients in the past five years referred to the outpatient department of St. Michael's Hospital for evaluation for cardiac surgery. From the group, 760 patients were selected for further diagnostic studies which included 119 angiocardio-

*Read before the Section on Chest Diseases, The Medical Society of New Jersey, May 1, 1957. This work is from the Departments of Cardiology and Thoracic Surgery, St. Michael's Hospital, Newark.

grams, 22 retrograde aortograms and 519 cardiac catheterizations. Surgery was done on 423 patients.

1. CONGENITAL HEART DISEASE

PATENT DUCTUS ARTERIOSUS

THE surgical treatment of patent ductus arteriosus, in general, is indicated whenever the diagnosis is made. The risk involved in the operative closure of the uncomplicated ductus is so small, that the procedure should be carried out in every case. The most favorable age for surgery is between three and ten years. At times it may be necessary to operate at an earlier age because of cardiac enlargement, congestive failure or marked retardation of growth and development. After the second decade, arteriosclerotic changes may occur in the pulmonary artery and the aorta in the region of the ductus making ligation and division technically difficult. However, surgery should not be withheld solely on the basis of age.

Bacterial endocarditis is not necessarily a deterrent to operation. Treatment of the bacterial infection should be carried out, and if controlled, the ductus should be excised three to six months later. If, despite medical therapy, response fails to occur, closure of the ductus should be attempted as a curative procedure.

The surgical treatment of patent ductus arteriosus with pulmonary hypertension is associated with a high operative mortality. Operative risk appears to be directly proportionate to the degree of pulmonary hypertension. When a right to left shunt develops, surgery is perilous. Sudden, complete closure of the ductus may be associated with a further rise in pulmonary-artery pressure resulting in sudden death or severe congestive failure. We have described[2] an operative technic for gradual occlusion of the atypical ductus. The operation is designed to circumvent the necessity of sudden, complete closure of the vessel. After partly occluding the ductus by placing purse-string sutures at the aortic and pulmonary artery attachments, polyethylene sheeting, previously activated in diacetyl phosphate, is wrapped around the vessel. The scarification induced by wrapping allows for the slow gradual closure, thus permitting gradual adjustment of the altered pulmonary hemodynamics.

AORTIC-PULMONARY SEPTAL DEFECTS

AN ENTITY producing signs and symptoms similar to patent ductus arteriosus is aortic pulmonary septal defect. Surgical repair of this lesion has been reported.[3] The success of the operation is dependent upon the size and location of the lesion, the hemodynamic changes produced and the skill of the surgeon.

COARCTATION OF THE AORTA

COARCTATION of the aorta is not, by itself, an indication for immediate surgery. However, operation becomes necessary (regardless of age) when excessive hypertension, uncontrollable congestive failure and cardiac involvement are associated with the coarctation. If the diagnosis of coarctation of the aorta is made in infancy, and no apparent adverse conditions arise under periodic clinical observation, surgery should be deferred until the second decade of life. In the presence of progressive symptoms in infants, immediate surgery should be considered despite high operative mortality. Prolongation of the waiting period may in itself be adverse because of the development of aneurysms, arteriosclerotic changes and medial necrosis of the aorta. For this reason, surgery is done, if possible, before fifteen years of age. Operation is not contra-indicated in older patients merely because of age, since more than 60 per cent of patients with coarctation die before the age of forty. Our oldest operated patient was forty-two years of age, and the youngest was six years old. Operative mortality is highest in the younger and older age groups.

Malformations of the aortic valve occur in 25 per cent of the cases of coarctation of the aorta. Surgery is not contra-indicated in this group unless the aortic valve deformity presents an advanced degree of obstruction or

insufficiency. In addition to the aortic valve pathology, another frequently associated abnormality is subendocardial fibro-elastosis. If the signs of cardiac embarrassment arise because of the subendocardial pathology, a dramatic response to surgery cannot occur, and the overall prognosis will not be altered significantly. Fibro-elastosis when extreme, contra-indicates surgery.

VASCULAR RINGS

VASCULAR rings are an uncommon congenital anomaly and many anatomic varieties may occur. The clinical findings together with x-ray examination of the chest with barium swallow and tracheograms are often adequate for a clinical diagnosis. However, the exact anatomic type can be determined only at operation, which successfully relieves the obstruction.

PULMONARY STENOSIS

THE success of surgery for obstructive lesions of the outflow tract of the right ventricle[4] depends upon the type of obstruction: valvular, infundibular or combined; and on the presence or absence of septal defects. Pulmonary valvulotomy as originally described by Brock,[9] is the operation of choice in pulmonary stenosis with intact septa. This technic had been applied also to pulmonary stenosis with interventricular septal defect (Tetralogy of Fallot)—but the operation was not entirely satisfactory because the blind technic prevented adequate surgical correction of the obstructive lesion, and did not allow for correction of other associated defects. Improvement in the surgical treatment of these lesions depends upon simultaneous correction of the multiple congenital deformities. This can be accomplished by direct-vision surgery with extra-corporeal circulation. Consequently, all patients with septal defects and pulmonary stenosis who do not require immediate surgery, should be withheld from closed operative technics until direct-vision surgery becomes available.

Repeated operations on the heart are associated with a high mortality. Patients with pulmonary stenosis and a ventricular septal defect requiring immediate emergency surgery, should have extra-cardiac operation of the Blalock or Pott's type as a temporizing procedure until open cardiotomy with extra-corporeal circulation can be performed.

There are cases of pulmonary stenosis with or without atrial septal defect, which demonstrate a progressive rise in right ventricular pressure, associated with clinical symptoms in whom emergency surgery is deemed necessary. These patients should be subjected to the Brock operation[9] immediately, by open cardiotomy if available—or by closed technic. If the patient's general condition permits, it may be possible to close the septal defect at the same time.

INTERATRIAL SEPTAL DEFECT

THE surgical treatment of interatrial septal defect depends upon the type of malformation and the degree of hemodynamic disturbance produced. Atrial defects, either of the *ostium primum* or the *ostium secundum* type, may vary from the rather innocent patent foramen ovale to the most complicated lesions involving alterations in the valves and complete absence of the septum. The success of surgery depends on the severity of the lesion. *Ostium secundum* abnormalities have a better operative prognosis than the *ostium primum*.

Every interatrial septal defect that demonstrates a left-to-right shunt with increased pulmonary flow and a rising vascular resistance should be corrected before the pulmonary vascular pressure approaches or exceeds systemic levels. When reversal of the shunt from right-to-left appears, surgery is contra-indicated. Operation should be done immediately on those patients in whom the pulmonary vascular resistance approaches the systemic resistance and who develop intermittent cyanosis on exercise. Because of the presently high operative mortality and imperfect operative technics, patients with a moderately increased flow but no alteration of pulmonary vascular resistance and without clinical symptoms, should

not be subjected to surgery at this time. They need periodic clinical evaluation and should be observed for changes in pulmonary hemodynamics. When evidence appears of an increase in pulmonary vascular resistance, surgical intervention becomes necessary. As operative technics improve, relaxation of the restrictions for surgical treatment of this lesion can be expected.

Indirect approaches for the correction of an interatrial septal defect, while partly successful in the repair of *ostium secundum* abnormalities, have given disappointing results in the *ostium primum* type of lesion. Because of the complicated anatomic varieties of interatrial septal defect, it is not always possible to know the type of lesion in advance. Repair under direct vision can attain adequate restoration of the anatomy—but, this is associated with a relatively high operative mortality. Closed operative technics have a lower operative mortality, but do not always allow satisfactory closure of the defect.

ANOMALOUS PULMONARY VENOUS DRAINAGE

ANOMALOUS pulmonary venous drainage is usually associated with inter-auricular septal defects. Partial anomalous pulmonary venous drainage is frequently corrected when the septal defect is repaired, while the total type drainage cannot be corrected by surgery at present.

INTERVENTRICULAR SEPTAL DEFECTS

IN DEALING with interventricular septal defects the same basic principles as in the treatment of interatrial septal defects should be applied. Small defects may not require surgical closure since they may not be associated with altered hemodynamics. Large defects, on the other hand, may produce extreme hemodynamic changes, so that early recognition is imperative. Closure by open cardiotomy with extracorporeal circulation has considerably improved the prognosis of the anomaly. The procedure should be undertaken before severe pulmonary vascular hypertension and reversal of the shunt from right to left occurs. Because of the present high operative mortality, interventricular septal defects having increased flow, but no alteration in pulmonary vascular resistance and pressure, should not be subjected to surgery at this time. In patients with a rising pulmonary vascular pressure tending to equalize the peripheral systemic pressure, but in whom a right-to-left shunt has not yet occurred, immediate surgical correction is indicated. Though operative mortality and complications are not negligible, the results of surgery are promising.

We are confident that the open cardiotomy and extracorporeal circulation technics are going to attain still further improvement and be established as the method of choice for the treatment of interventricular septal defects.

NON-SURGICAL LESIONS

THE following congenital lesions are not amenable to surgery at present: truncus arteriosus, pseudotruncus, transposition of the great vessels and their variants, Ebstein's anomaly, tricuspid atresia and anomalous origin of coronary arteries.

We feel that surgery for interatrial and interventricular septal defects with or without pulmonary stenosis, and other complicated congenital or acquired lesions, should be attempted only in properly equipped centers with highly skilled, well coordinated surgical and medical teams, whose knowledge of the pathological and physiological hemodynamics are well understood and applied.

2. ACQUIRED HEART DISEASE

MITRAL STENOSIS

SURGERY for mitral stenosis is now a standard accepted operative procedure with good results in properly selected cases. The indications and contra-indications for surgery have been outlined in a previous communication.[5] Over recent years the indications for surgery have been broadened and the operative mortality has been considerably reduced. The patient with mitral stenosis must be sub-

jected to surgery at the proper time, *i.e.* when the operative risk is least and the chances for relief and rehabilitation are the greatest.

Patients with mitral stenosis may clinically be divided into four groups.

Group I. Persons with the characteristic murmur of mitral stenosis who are asymptomatic and do not have laboratory evidence of pulmonary hypertension do not require surgery. However, asymptomatic patients, who demonstrate progressive pulmonary hypertension, should be operated upon.

Group II. Patients with mitral stenosis who have pulmonary hypertension and whose symptoms are stabilized with medical therapy represent the ideal candidate for surgery.

Group III. Patients with progressive symptoms and right ventricular failure who are still able to respond to medical treatment, should be subjected to operation promptly. Operative mortality of this group should not be higher than 2 per cent.

Group IV. Cases of mitral stenosis with irreversible failure represent the "salvage" group. Their operative mortality is as high as 25, or even 50 per cent. Surgery should not be denied to carefully evaluated patients, since many may show definite improvement postoperatively.

MITRAL INSUFFICIENCY

For the purpose of simplification four major types can be distinguished: (1) mitral insufficiency resulting from dilatation of the mitral ring with intact leaflets, as seen in active rheumatic carditis and congestive heart failure frequently responds to medical therapy. (2) Mild mitral insufficiency with distorted valve cusps, but with an intact ring usually does not present symptoms, and therefore does not require surgery. (3) Mitral insufficiency of a mild degree often co-exists with mitral stenosis. Mitral commissurotomy frequently restores the mobility of the previously fused cusps and corrects the regurgitation. (4) Patients who have long-standing mitral stenosis and who have damaged valve leaflets and a dilated mitral ring with significant involvement of the chordae tendineae usually present evidence of extensive involvement of the myocardium and it is doubtful that such cases can respond to any type of operative treatment.

Various surgical methods have been devised either to reduce the circumference of the mitral ring or to support the damaged cusps. The results are not encouraging and operation solely for the treatment of mitral regurgitation cannot be recommended at this time.

AORTIC STENOSIS

The surgical treatment of aortic stenosis in our experience thus far has not been satisfactory. About 90 per cent of aortic valves operated for stenosis are calcified. Calcification tends to obliterate the commissures almost completely, so that commissurotomy becomes very difficult and does not restore the functional capacity of the valve. Embolization of calcium particles from fractured valves may also complicate the surgical procedure. On occasion, calcium deposition has been found to extend from the aortic valve on to the ring and into the aortic wall. Uncontrollable extension of the commissurotomy incision along the brittle structure can result in the development of rupture of the aorta or acute aortic insufficiency—both rapidly fatal complications.

The enlarged left ventricle associated with aortic stenosis tends to be highly sensitive and irritable. Therefore, the transventricular approach to aortic commissurotomy is associated with a high incidence of ventricular arrhythmias, cardiac standstill and ventricular fibrillation. These abnormalities represent the major cause of operative deaths. The transaortic approach to the valve has reduced but not eliminated these complications.

The size of the left ventricle and the functional capacity of the myocardium are important factors in the determination of the success of surgery. Because of the operative difficulties and the peculiar natural history of the disease with its associated anatomic derangement, the surgical treatment of aortic stenosis should be withheld until direct-vision surgical technics are available. Even then, re-

sults will be dependent upon the presence or absence of calcification of the valve and the size and functional capacity of the left ventricle. Early cases in which commissure lines are still visible and in which there is little or no valvular calcification, together with a good functioning left ventricle, represent the ideal cases for surgery. In such cases the demonstration of a significant gradient of pressure between the left ventricle and aorta must be definitely established by left heart catheterization. Venous catheterization should also be performed to clarify altered hemodynamics and exclude the possibility of left ventricular failure. These tests will also help to rule out the presence of other cardiac lesions.

AORTIC INSUFFICIENCY

THE surgical treatment of aortic insufficiency has been limited largely to the work of Hufnagel.[6] The introduction of a plastic valve into the descending thoracic aorta is accompanied by a relatively high operative mortality and numerous operative difficulties. Furthermore, it does not solve the problem. It has been our experience that patients with aortic insufficiency, having physiologic peripheral signs and cardiomegaly, but who are not decompensated, may be considered candidates for this operation, provided the surgeon is aware of its limitations. When cardiac decompensation is present the operation is not recommended.

TRICUSPID STENOSIS

TRICUSPID stenosis rarely appears as an isolated lesion in rheumatic heart disease. It is often associated with tricuspid insufficiency and with mitral and aortic valvular lesions. It may, however, occur with mitral stenosis, and because of the similarity of some of their clinical features, errors in diagnosis can be made. Every case of rheumatic tricuspid stenosis, isolated and combined, producing significant hemodynamic changes, should undergo operative treatment. Stenosis of both — the mitral and tricuspid valves can be corrected simultaneously, provided the mitral valve is attacked first. Functional tricuspid stenosis is usually the result of pulmonary hypertension secondary to mitral stenosis, and is many times diagnosed as an organic lesion. In such instances surgery of the tricuspid valve is not indicated, but is corrected by mitral commissurotomy.

The surgical treatment of congenital tricuspid stenosis should not be undertaken at this time, because this lesion is so often associated with other cardiovascular congenital deformities such as auricular septal defects, patent ductus arteriosus, interventricular septal defect, and transposition of the great vessels. It is hoped that in the future direct-vision surgery with extracorporeal circulation will allow for the complete correction of the multiple defects associated with tricuspid stenosis. Isolated congenital tricuspid stenosis is a rare abnormality and surgery in these cases is indicated, although the results are poor.

MULTIVALVULAR LESIONS

MILD aortic insufficiency not producing hemodynamic changes may be associated with mitral stenosis and is not a contra-indication to mitral commissurotomy. However, in the presence of predominant dynamically significant aortic insufficiency, mitral commissurotomy is contra-indicated. The present results of surgery, in combined significant aortic stenosis and mitral stenosis, are not encouraging and we do not recommend at this time simultaneous correction of both lesions. In the future, with the perfection of direct-vision surgery and extracorporeal circulation, operations on these multivalvular lesions will probably be feasible in properly selected cases.

CONSTRICTIVE PERICARDITIS

CONSTRICTIVE pericarditis when symptomatic is an indication for surgery. Operation should be done before irreversible myocardial changes occur. However, diffuse myocarditis and subendocardial fibro-elastosis may mimic constrictive pericarditis and must be ruled out before surgery is considered. Constrictive pericarditis, involving the left ventricle or the atrio-ventricular groove, may simulate mitral stenosis, and it is essential that an accurate appraisal of the situation be made.

3. DEGENERATIVE HEART DISEASE

CORONARY ARTERY DISEASE

EXPERIMENTS by Beck,[7] confirmed in our laboratory, have demonstrated that the blood supply of the myocardium can be improved by operative methods. Surgical revascularization of the heart can protect the test animal from sudden occlusion of a major coronary artery. The success of the surgery depends on the addition of oxygenated blood to the coronary circulation, the development of new intercoronary communications and the extension of existing anastomotic channels. Unfortunately the efficacy of a revascularization procedure cannot be measured objectively in the human at this time. The wide variability of the natural course of arteriosclerosis of the coronary arteries and the large number of factors influencing the progress of the disease, make evaluation of the surgical treatment difficult. The final judgment of the feasibility of operative treatment of coronary artery disease must wait upon the accumulation of a large number of cases with adequate long-term postoperative study, and accurate physiologic and biochemical determinations of the myocardium, which as yet have not been accomplished.

Before any operation can be applied clinically it must be demonstrated in the animal laboratory that the given procedure can add significant quantities of oxygenated blood to the effective coronary circulation, and that anastomotic channels are improved. Very few operative technics fulfill the necessary criteria for a successful surgical procedure. The Beck I procedure does meet laboratory requirements. Our experience clinically has shown that this operation is well tolerated, has little or no operative mortality and results in significant improvement in a large proportion of cases.[8]

In coronary artery disease, operation should not be performed indiscriminately. The need for surgery should be well defined, and the purpose of operation and an understanding of the physiologic principles of surgical re-vascularization of the heart, as well as the limitations of operative technics should be considered properly. Although promising results have been obtained, thus far, a final evaluation has not been completed.

Recently ligation of the internal mammary arteries and endarterectomy of the coronary vessels have been reported. The basic principles underlying these procedures are physiologically and anatomically unsound, and we do not recommend them.

SUMMARY AND CONCLUSIONS

1. The necessity of accurate clinical diagnosis and hemodynamic evaluation has been stressed.

2. Complicated congenital and acquired lesions should be attempted only in well organized, well staffed and properly equipped centers.

3. The importance of the development and future improvement of direct-vision surgery with extracorporeal circulation for the correction of surgically amenable lesions is emphasized.

The authors are indebted to the New Jersey State Department of Health for assistance in various phases of this study.

27 West Market Street (Dr. Antonius)

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Aaron Weiner, M.D.

Fair Lawn

The Allergic Survey*

FACT AND FANCY

Have we become scratch happy? Yes, says Dr. Weiner in this brief critique of allergy surveys. He questions the basic importance of the "complete" allergy test, and the blissful assumption that avoidance and desensitization, as suggested by the skin tests, will cure the patient.

In the mind of the public, the allergic survey consists of numerous "scratch" tests, the specificity of which is unquestioned. Many believe once the tests are performed, the diagnosis is made and that treatment based on the results of these tests ultimately leads to a cure. This type of thinking, unfortunately, is shared by some of our colleagues. As a result, patients are sent to an allergy laboratory where a technician performs "scratch" tests. The physician then receives a bottle of medicine with a dosage schedule made up by the technician. In addition he is instructed to have the patient avoid the positive reacting foods, sometimes twenty or thirty of them, some of which may be important. Finally, either the patient ends up with malnutrition or a psychic disturbance. Often in desperation he decides that he would rather live with his allergy, because treatment is worse than the disease!

The allergic survey consists essentially of a detailed history, a physical examination, laboratory tests, x-rays if indicated and just enough skin tests to corroborate the diagnosis suspected in the course of taking the history. If history suggests the diagnosis, relatively few tests are done. If repeated history taking and study of the environment still leave us in the dark, more skin tests are necessary with the hope of determining the causes.

In the end, however, the diagnosis is clinical. Exposure to the allergen, either by inhalation, ingestion or contact, gives a reaction. A thorough history orients and sometimes makes the diagnosis. Complete skin testing is seldom required. If the patient has hayfever, tests for the pollens are indicated. For completeness, tests for air-borne molds and house dust may be included. If the history suggests environmental factors, those substances which are present in the patient's environment should be tested. If the history gives no clue, complete skin testing with inhalant and food allergens may be indicated.

With patience and proficiency in taking a history, a chance remark may give a clue as to the causative factors. Case one illustrates this point.

CASE ONE

A 27-year old married woman gave a history of early and late hay-fever for the past ten years. There was also a history of severe constipation and generalized edema as far back as she remembered. Usually, she had bowel movements only once weekly. The edema was so severe at times that her clothes did not fit her and her face was almost unrecognizable. Her mother thought that this condition was "natural" and there was nothing to be done about it. Repeated history taking revealed no particular pattern. No specific atopen could be implicated until at the second visit she recalled that when she had her "sweet sixteen" party, she ate a tremendous amount of "pizza" which she had never tasted before. Immediately

*Read at the Annual Meeting (Allergy Section) of The Medical Society of New Jersey, in Atlantic City April 30, 1957.

following this party, the edema and constipation became more severe and had remained so up to the time of the examination. Further questioning seemed to point to wheat as the possible culprit. She was placed on a wheat-free diet for five days. On the fourth day, she started to improve and on the fifth day, she felt quite well. Three heavy meals on consecutive days resulted in an explosive reaction with severe generalized edema so that she was confined to bed. On a wheat-free diet she has lost twelve pounds in weight, moves her bowels every day and feels and looks "wonderful." She can tolerate wheat once every two weeks but has a severe reaction if she has it on two or three consecutive days.

At times, a detailed history orients the diagnosis but even carefully performed intradermal tests do not corroborate the diagnosis. Other modalities such as sniff tests and actual contact with the responsible antigen are often necessary.

CASE TWO

A 60-year-old man gave a history of bronchial asthma of two years' duration since moving to North Haledon, New Jersey, from New York City. The condition was worse in the winter time and indoors. Skin tests with a group of inhalants gave a moderate reaction to dust and negative reactions to the other inhalants including the molds. There was no clinical sensitivity to dust. He said that his cellar was damp, had a musty odor and that a dark, moldy substance grew on the walls. I visited the patient's cellar. A sabouraud plate was exposed for 30 seconds on the floor and later, the mold which grew on the plate as well as the scrapings from the wall were identified as hormodendron. On coming up from the cellar, the patient suffered a severe asthma attack which had to be relieved with 0.4 cubic centimeters of epinephrine, 1 to 1000 subcutaneously. Subsequently, sniff tests with talcum as a control, then with alternaria, aspergillus, penicillium and finally hormodendron, were done. With the latter, after 10 minutes, the patient had a severe asthma attack, which required subcutaneous epinephrine. The intradermal test for hormodendron was negative. This patient sold his house, moved back to New York City and has been symptom free for the past four years.

This type of case is seen frequently in the practice of the average allergist because of the lack of specificity of available mold extracts. False negative reactions are almost as frequent as false positive reactions. In these cases a well detailed history is a good starting point for an accurate diagnosis.

There are situations where skin tests are of prime importance. The history, no matter how meticulously taken may not give the slightest hint as to the identity of the allergen. Such a case is illustrated below.[1]

CASE THREE

A 7-year old girl gave a history of non-productive cough with sporadic attacks of wheezing which were quite severe. No pattern could be determined in spite of several hours of history taking. Intradermal testing with a group of weak inhalants produced a marked reaction to dust and a very marked reaction to silk extract (raw silk fibre) 100 protein nitrogen units. The silk test (100 P.N.U.) was repeated intradermally to rule out the possibility of error. Five minutes after the second test with silk, the child suffered a marked asthmatic seizure with cyanosis and dyspnea. Recovery occurred in 30 minutes after two subcutaneous injections 0.4 cubic centimeters of epinephrine, 1 to 1000. Pertinent questioning then revealed that the child's grandfather was a dealer in remnants and often brought some of these cloth pieces home to the patient. Investigation of these remnants showed them to be 20 per cent silk. To substantiate the diagnosis, passive transfer and indirect passive transfer were positive for silk. The patient improved with simple avoidance of silk. Symptoms continued to re-appear following injections of silk extract for immunization and persisted for 24 hours after each injection. Marked bronchial symptoms appeared when the patient wore a silk collar for a few hours and, another time, when the father wore a silk tie. Immunization therapy was discontinued. This child did very well with strict elimination of silk from her environment.

All too frequently, a thorough history, physical examination and complete testing leave us completely mystified. It sometimes requires a long period of observation to determine the responsible allergen. Such a solution may come about from a chance remark made by the patient.

CASE FOUR

An 8-year old boy had a history of mild nasal symptoms, severe tearing and pruritis of the eye lids and conjunctivitis beginning in May and continuing to the first frost for the previous two years. During the remaining months he was symptom free. Intradermal tests with representative inhalants including four common molds were negative except for a moderate reaction to dust which was not clinically significant. Treatment for one year with dust extract, a stock vaccine, a grass mixture, plantain and ragweed was ineffective. One day the patient's mother observed that when the child stayed home, he had minimal symptoms. When he played in front of the house he had moderately severe symptoms. When he played in the

back yard, he had very severe symptoms and more so when it was humid and windy. Further investigation revealed that shortly before the onset of symptoms, a builder in the area had diverted a stream resulting in the collection of stagnant water about twenty-five feet behind the house. A sabouraud plate opened for ten seconds at this swamp resulted in a growth, 5 days later, of many different types of mold colonies. The patient accompanied me to this area. He was symptom free before starting out but became extremely uncomfortable after a few minutes so that he had to leave and return to his house. Identification of these colonies was not made due to technical difficulties at the time. The child, however, was immunized with a mixture of air-borne molds commonly found in this area in addition to the dust and vaccine with excellent result. More recently, the dust and vaccine were discontinued for 2 months with no harmful effect. However, when the mold mixture was not given for 2 months, the symptoms gradually returned. The patient is now maintained perennially on the mold mixture. Intradermal tests to the 1000 protein nitrogen unit strength of the molds used in the mixture were entirely negative.

In recent years, skin tests to the foods have assumed a minor role in the diagnosis of food allergy. Many physicians do not perform these tests at all. Sheldon *et al.*[2] state that rather than give a patient a test negative diet, it would be more desirable to utilize elimination and provocative diets only.

The common practice of sending patients to a commercial laboratory, as if he were an automobile taken to a service station for testing, is to be deplored. Frequently, it ends in failure. This discredits food allergy in the minds of the physicians and especialiy patients who, as Rowe[3] aptly observed, "have paid a fee for such tests which would have given them an allergic investigation, including a proper history, physical examination and other laboratory tests by an experienced allergist who realized the fallibility of skin testing. That a well taken history is more important than skin testing must be realized by all physicians."

The specificity of mold extracts for skin testing has been investigated for many years. Experience would indicate that positive intradermal tests with concentrated fungus extracts are unreliable. Such tests were performed in our clinic with twelve of the most prevalent mold allergens in this area on one hundred consecutive patients with the 1000 protein nitrogen unit extracts. About 80 per cent of these patients gave significant positive reactions. Only about 10 per cent of the patients tested were mold sensitive. According to Black,[4] in these cases, the diagnosis is "sometimes presumed rather than proved."

Clinical mold sensitivity associated with negative skin tests to the allergen is well known. Feinberg[5] states that a thorough history will tell him whether his patient is mold sensitive. Browning[5] agreed that "This is just about as good a plan as using our extracts or perhaps a little better plan."

SUMMARY

1. The physician should be as well acquainted with allergy as he is with cardiology or gastro-enterology.

2. He should have enough fundamental knowledge to recognize an allergic condition and he should be able to diagnose and treat it adequately.

3. He should consult with an allergist on the same basis as with any other specialist as soon as he realizes that he needs help.

These are facts. The following are fancies:

1. Complete allergy testing is of primary importance in order to arrive at a diagnosis.

2. Good results will always follow the routine of avoidance and desensitization as indicated by the positive skin tests.

Your patient is caught in the maelstrom. He pleads for a rational approach to his problem. He is overwhelmed by the nightmare of innumerable "scratch" tests. He surrenders to his doctor, when life becomes intolerable.

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Orange

Hernia of the Veriform Appendix

Report of Two Cases in Infants*

Two instances of hernial appendicitis in babies are here added to the extremely small list of such cases.

In 1731, DeGarengeot[1] first described an inguinal hernia sac containing the veriform appendix. Up to 1946 less than one hundred cases had been reported[2] in infants less than ten months of age. Loranger[3] cited the case of an infant 2½ weeks old with acute appendicitis in a hernia sac. This is the youngest patient recorded to date. Merling[4] in 1846 reported the first strangulated appendiceal hernia successfully operated upon. In the early cases, operation was done only after abscess formation had occurred and then only an incision and drainage was undertaken. It was not until the beginning of the twentieth century that removal of the appendix was attempted routinely through the hernia sac.

We here report two cases in infants, successfully treated by excision of the appendix and high ligation of the hernia sac. In the first case, the diagnosis was made pre-operatively.

CASE ONE

A ten month old baby was admitted with an irreducible right serotal mass of two weeks' duration which had suddenly become painful and tender. There was no vomiting nor anorexia. The child had been in excellent health since birth. He was an irritable, agitated little boy with a temperature of 103. His pulse was 128. The abdomen was flat, soft, and non-tender. There was a swollen tumor mass in the right groin and scrotum in which the appendix and swollen mesoappendix could be easily palpated. The leucocyte count was 38,000; polymorphonuclears, 71 per cent; erythrocytes, 4.1 million per cubic milliliter; and sickling preparation negative.

Under ether anesthesia by open drop, a right inguinal incision was made down through the aponeurosis of the external oblique muscle. The hernia sac and the right testicle were delivered out of the wound; the sac was opened and found to contain an appendix adherent to the testicle by fresh fibrinous adhesions. The base was somewhat constricted at the internal ring. The appendix was excised, doubly ligated but not inverted and the cecum was replaced in the abdomen. The hernia sac was transected in its mid portion. The proximal portion of the sac was gently dissected from the vas and a high ligation was performed. The distal portion of the sac was opened but no attempt was made to remove it from the testicle. The external oblique aponeurosis was closed with interrupted black silk as was the skin.

The baby's postoperative course was uneventful. He was given 100 milliliters of whole blood on the first postoperative day which raised his hemoglobin to 7.2 Grams. The white blood count remained elevated to 21,000 up to the time of discharge on the fifth postoperative day. However, his clinical course was tranquil when followed at weekly intervals for two months and his anemia responded to iron therapy.

Pathological Report: The specimen was an appendix which measures 9.5 by 1 centimeter. The tip of the serosal surface appears hemorrhagic with beginning necrosis. Microscopic sections show an intact mucosa with small and large lymph follicles scattered throughout. There is early evidence of inflammation on the serosal surface with infiltration of leucocytes and fibrin deposits.

Diagnosis: Periappendicitis.

CASE TWO

A thin, three month old boy was admitted with a tender irreducible mass in the right scrotum of twelve hours' duration. The mother noticed the mass on the previous evening and said that it had become increasingly tender. The infant had vomited four times during the night and had exhibited

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marked restlessness. The child had been born by a normal spontaneous delivery with no illness since birth. On admission, his temperature was 103, pulse 120, respiration 24 per minute. The abdomen was soft and non-tender. There was no distention. The right inguinal region was swollen to the size of a walnut and exhibited marked tenderness. The mass was irreducible. The testicle was noted in the scrotum. His white cell count was 32,000; polymorphonuclears, 75 per cent; erythrocytes, 3 million per cubic milliliter; hemoglobin, 9.8 Grams.

The infant was given 150 milliliters of Hartman's solution by clysis, sedated with secobarbital 0.01 Grams and scopolamine 0.00002 Grams and taken to the operating room three hours after admission. Using ether anesthesia by open drop a right inguinal incision was made down through the aponeurosis of the external oblique muscle. A congenital scrotal hernia sac containing a gangrenous appendix was found. The serosa of the appendix was adherent to the sac and the tip was fixed to the testis by fibrinous adhesions. These were incised and the appendix excised and the stump doubly ligated. A high ligation of the hernial sac was accomplished. No further attempt at hernia repair was made. A layer closure with 0000 chromic catgut was carried out, silk was used in the skin. Immediate postoperative condition was good.

The child was given one further clysis and this was followed by formula. Temperature gradually returned to normal on the fourth postoperative day. There was minimal scrotal edema which had completely subsided by the eighth postoperative day when the child was discharged.

Follow-up one month later revealed no evidence of hernia.

Pathological Report: The specimen consists of a "U" shaped appendix 50 millimeters long and 7 millimeters in diameter. The outer surface is dark gray. Cut surface reveals a necrotic wall. Microscopic sections show the lumen to contain necrotic debris and acute inflammatory exudate. The mucosa is entirely degenerated and replaced by hemorrhagic and inflammatory exudate. There is an acute inflammatory process throughout the wall with cellular infiltration composed chiefly of neutrophiles. There are many areas of necrosis.

Diagnosis: Acute appendicitis with gangrene.

It is probable that in all cases of indirect inguinal hernia of the congenital type there is an open funicular process present at birth. Hernia of the appendix may originate in either of two ways: (a) During the fourth fetal month, at the time of the descent of the cecum into the right iliac fossa, adhesions may be formed between the appendix and the posterior parietal peritoneum over the testis or gubernaculum. In such a case, the appendix may be then drawn into the inguinal canal with the descent of the testes. (b) Because of its location low in the right iliac fossa it is easy to picture the appendix tip falling into an opening in the internal inguinal ring and being forced into the inguinal canal by intra-abdominal pressure.

The same factors that are responsible for intra-abdominal appendicitis are also the cause of hernial appendicitis. In addition the constriction of the blood supply of the appendix at the internal inguinal ring and direct trauma to the exposed appendix in its superficial position play an important role.

In the first case, no evidence of strangulation was found but rather inflammation of the serosal layer and adhesions to the testicle indicative of incarceration. Careful examination of this hernia enabled us to palpate clearly and identify the appendix and mesentery contained therein pre-operatively.

The second child had constriction at the base of the appendix but not of sufficient degree to cause strangulation. The tip of the appendix was swollen and gangrenous while the base was relatively normal. It appears that this case was one of acute appendicitis rather than strangulation of an appendiceal hernia.

SUMMARY

Two cases of hernial appendicitis have been presented in infants under one year of age. The incidence and mechanism of this phenomena have been discussed.

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279 Ridgewood Avenue (Dr. Morton)

John W. Gray, M.D.

Newark

Early Diagnosis in Gouty Arthritis*

The old picture of tophaceous degeneration of hands and wrists, should, Dr. Gray says, "in the light of our present knowledge, become museum pieces, never to be reproduced." The key is early diagnosis.

Evaluation of diagnostic aids in gouty arthritis is pertinent at this time. Advances during the past decade have revolutionized the treatment of gout. Through isotope studies,[1] a uric acid pool as high as fifteen to thirty times normal was found to exist in gouty subjects. This pool consists largely of uric acid deposits in tissues around joints and in the kidneys. Potent uricosuric agents[2] including Benemid® and Butazolidin® were also discovered.[3] These newer drugs are needed for controlling the pool in severer cases.

With this knowledge and these implements at our disposal, irreversible destructive changes from gout may be avoided. If an early diagnosis is made, *tophaceous gout should be prevented.*

The diagnosis of acute gouty arthritis is not difficult when there are recurring attacks with severe symptoms developing within a few hours, especially in the big toe joints; with complete recovery between attacks; and with response to colchicine within twenty-four hours. The diagnosis becomes more difficult, however, in chronic gouty arthritis when there is no definite history of acute episodes or remissions in the early stages and when the clinical manifestations are indistinguishable from rheumatoid arthritis. This situation occurs more frequently in women than in men. Only two of nine cases of gouty arthritis in women observed in my private practice had typical gouty attacks. The others resembled rheumatoid arthritis.

We have been taught that gout occurs twenty times more frequently in men than in women. These figures may still hold for the younger group but will need revision as more postmenopausal women who have an increased susceptibility to gout are included. Kuzell[4] reported 504 cases of gouty arthritis; of these 26 per cent were women. Seventeen per cent of the males were less than forty years of age while only 9 per cent of the females were that young.

On the other hand, the incidence of rheumatoid arthritis in women is three times higher than in men. Is it not possible that the atypical

*Read May 1, 1957 before the Rheumatism Section of The Medical Society of New Jersey.

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picture of gouty arthritis seen in younger women may be affected by a complicating rheumatoid arthritis? Is it not possible that women with a gouty diathesis develop clinical gout in certain joints where resistance is lowered by rheumatoid arthritis rather than in the usual sites?

Gout and rheumatoid arthritis may exist in the same patient. I illustrate this by a case. The patient was a young woman of thirty-three who had been treated unsuccessfully for rheumatoid arthritis for eight years. Various corticosteroids were used. The arthritis began in the hands and later involved the feet. In the beginning, for a year or two, the pain was intermittent but when swelling developed it was continuous and became progressively worse. There was symmetrical bilateral fusiform swelling of the proximal interphalangeal joints typical of rheumatoid arthritis (Figure 1). Positive sheep cell agglutination tests, 1 to 112 on two occasions, were of diagnostic value. The blood serum uric acid done repeatedly was above 5 mg. per cent on one occasion. The colchicine therapeutic test was equivocal. Brucellosis tests and "L. E." cell search were negative.

At this point only a diagnosis of rheumatoid arthritis could be made. X-ray examination, however, revealed definite evidence of tophaceous gout. The ends of many phalanges and metacarpals as well as metatarsals showed rounded areas of sharply marginated punched bone destruction. The most marked changes were in the proximal interphalangeal of the right middle finger and right second metacarpophalangeal (Figure 2) and the right first metatarsophalangeal (Figure 3).

This patient who had failed to respond to other forms of treatment responded promptly to Butazolidin® and then to Benemid®. Subjective symptoms were quickly alleviated and swelling gradually subsided. So the coexistence of rheumatoid arthritis and gouty arthritis became obvious.

The fate of this patient, if untreated, might have been as tragic as that of a woman I observed several years ago. She had suffered from arthritis for twenty years. The swellings in Figure 4 are characteristic of advanced gouty arthritis and the urate crystals shown in Figure 5 were obtained from milky fluid aspirated from the wrist swelling. The x-ray photograph in Figure 6 shows unusually extensive urate deposits around all of the joints, large tophaceous degenerations of hands and wrists, bone destruction and irreversible deformities. In the light of our present knowledge, these specimens should become museum pieces, never to be reproduced.



Figure 1. Photograph right hand. Proximal interphalangeal fusiform swelling. Metacarpophalangeal swelling of thumb, index and little fingers. Slight interosseous atrophy. The left hand was similarly involved.



Figure 2. X-ray of hands. All interphalangeals and metacarpophalangeals show less loss of joint space. Ends of many phalanges and metacarpals show rounded areas of sharply marginated punched bone destruction. The most marked changes are in the proximal interphalangeal of right middle finger and right second metacarpophalangeal.



Figure 3. X-ray of feet. Punched out areas in right first metatarso-phalangeal and destructive changes in other metatarsal heads, especially those of the little toes.



Figure 4. Advanced gouty arthritis. Large periarticular tophaceous swellings, subluxations and deformities.

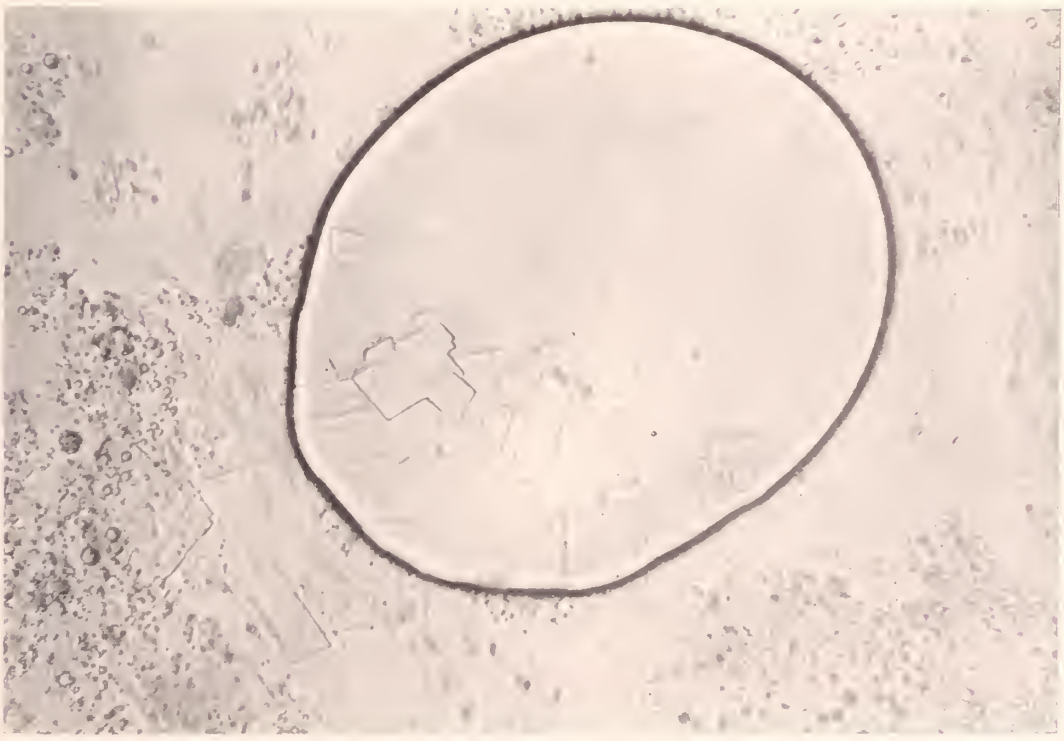


Figure 5. Microphotograph. Uric acid crystals from tophaceous swelling aspiration.



Figure 6. Large uric acid deposits around joints and tophaceous degeneration in wrists.

142 Clinton Avenue

Niacinamide in Arteriosclerosis

In a series of 50 cases of arteriosclerosis, the signs and symptoms which are partly reversible showed significant improvement after treatment for two months with parenteral niacinamide hydroiodide in combination with iodides.* There was some alleviation in every case. Average age of the patients was 61. Significant relief of the following symptoms was observed: vertigo, depression, disorientation, excessive fatigue, vague abdominal distress headache, emotional instability and anorexia. The medication used was a niacinamide combination twice weekly by intramuscular or slow intravenous injection. No untoward effects were observed and there was not a single case of iodism. The rationale depends on the close relationship between iodism and pellagra, both of which are associated with porphyrinuria and impairment of the co-enzyme mechanism. The action of niacinamide hydro-iodide in prevention of iodism is the same as that of niacinamide for pellagra. Reference is made to the report of an ophthalmologist who noted significant improvement of the retinal vessels following use of this combination.

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Robert J. Ryan, M.D.*

Trenton

Endometrial Carcinoma

An analysis of the technic used in the major medical centers of the country indicates that in endometrial carcinoma the highest survival rate follows irradiation combined with surgery. In this brief paper Dr. Ryan reviews the different technics and suggests ways of assuring earlier diagnosis.

Endometrial carcinoma and its treatment have been focal points of interest in the past ten years. This is evidenced by the two schools of thought on the subject. One advocates pre-operative radiation followed by panhysterectomy. The other believes that surgery alone is adequate therapy. This paper will review some of the Philadelphia, New York, Chicago and Boston opinions.

Endometrial carcinoma is usually adenocarcinoma with glandular elements made up of tall columnar cells. The stroma is well vascularized. Adeno-acanthoma may occur in the fundus. These are mixtures of squamous and columnar cells and may portend a less favorable prognosis. Grossly the lesions may be diffuse, polypoid or circumscribed.[1] Extension is to adnexa, cervix, vagina, intestine, pelvic and aortic nodes and then distantly to lung and bones. This comprises 20 to 30 per cent of uterine carcinoma.[2]

Excessive bleeding before the menopause, associated with a cessation of menses after the age of fifty are indications that endometrial neoplasm must be considered. There may be a mucopurulent or serosanguinous or grossly bloody uterine discharge present for more than a year postmenopausal.[2] Pain occurs only in advanced cases and is a grave symptom.

The uterus may be enlarged by a soft mass. The cervical os may be patulous with an intrauterine mass. Fibroids or cervical polyps do not preclude endometrial carcinoma as the cause of "spotting." Actually about one-fourth of the cases of carcinoma of the endometrium are associated with uterine myomas.[5] This brings into bold focus the need of a diagnostic dilatation and curettage before hysterectomy for uterine myomas, so that adequate surgery may be done.

Histologic study of uterine scrapings is mandatory. One must be cautious and differentiate hyperplasia from adenocarcinoma. Papanicolaou smears are positive in 80 per cent of the cases.[2]

It would be wise to examine all uteri immediately after removal for gross findings of endometrial carcinoma. The curettings of a neoplasm are granular and cheeselike. A frozen section to confirm presence of gross malignancy may be in order.

Five to ten per cent of endometrial carcinoma are very lethal and may metastasize before being clinically evident.[7] We must awaken the public to these symptoms and abolish the myth that abnormal bleeding at the menopause is to be expected.

Many authors [2] are of the opinion that overactivity of the endometrium around the meno-

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pause is an ominous sign.[5] Although the proof of the carcinogenic role of endogenous and therapeutically administered estrogens in endometrial malignancies is not conclusive, many workers imply estrogens may be etiologic factors.[4] Low parity, diabetes mellitus and overweight, in addition to heredity may be contributory.[2] Radio-therapeutic menopause and previous radiation therapy for benign uterine bleeding and other non-malignant conditions may be factors.[5]

When estrogens have been administered, great care must be exercised in distinguishing hyperplasia of the endometrium from carcinoma. If hyperplasia, the microscopic picture may be reversible with cessation of estrogens.[7]

TREATMENTS AND RESULTS

IN ANY discussion of treatment, one must consider the stage of the disease and the state of the patient. One simple classification clinically is: Stage I with growth confined to uterus, and Stage II with extension beyond the uterus, according to McCartney.[2] Histologic rating into four grades of increasing malignancy ranging from well preserved glandular pattern to anaplastic non-glandular architecture, seems acceptable and in accord with Broder's concept.[3]

Failure to do a diagnostic curettement with the unusual uterine bleeding leads to inadequate treatment because ovaries and other adnexae may be left in situ with an unsuspected endometrial neoplasm. The only accepted methods of treatment are:

(a) irradiation therapy alone,
(b) surgery alone, and
(c) combined irradiation and surgery.

The 5-year survival rates from various clinics are:

(a) irradiation alone—40 to 50 per cent
(b) surgery alone—60 per cent
(c) irradiation followed by surgery—70 to 80 per cent

Geographically, one might summarize the concepts of therapy of endometrial carcinoma in the table below.

Logically enough irradiation therapy alone may be of choice if the lesion is technically operable but the patient is a poor surgical risk, as occurs in about 20 per cent of cases. Intra-

Center:	Author:	Treatment of Choice:
Philadelphia	Kimbrough [5]	Intrauterine radium (4000 mg. hrs.) followed in 4 to 6 weeks by total abdominal hysterectomy with bilateral salpingo-oophorectomy and removal of upper half of vagina and occasional lymphadenectomy.
Chicago	McCartney [2]	5000 mg. hrs. of irradiation in 4 to 5 days followed by definitive surgery in 6 to 8 weeks (if confined to corpus, then as above—if endocervical, a Wertheim type operation is done).
Chicago	Schmitz [3]	"Y" radium application into uterus giving 2000 mg. hrs. 3 times and 4000 r of 1000 KV x-ray divided. In 6 to 8 weeks, a total abdominal hysterectomy with bilateral salpingo-oophorectomy and lymph node dissection is done.
Boston	Swinton, Schwyzer, Sass [1]	Removal of total uterus, tubes, ovaries, portion of vaginal cuff, endocervical fascia and wide margin of parametrial tissue. (No acceptance of combined method.)
New York	Corscaden, Tovell [7]	Intracavitary radium followed by hysterectomy with bilateral salpingo-oophorectomy.
New York	Brunschwig Murphy [6]	Radical panhysterectomy and pelvic node excision (no planned pre-operative radiation).

uterine radium alone or supplemented with deep x-ray may be used. Fifty to 100 milligrams of radium over a period 96 to 120 hours consecutively is suggested [2] so that 4000 to 6000 milligram hours are given. Multiple small capsules of radium are used. This technic yields approximately 50 per cent 5-year survival.

SUMMARY AND CONCLUSIONS

(1) Early diagnosis with a willingness to do a dilatation and curettage in the face of abnormal uterine discharge, whether mucopurulent or bloody (especially in the menopausal and post-menopausal groups) may make possible an even higher salvage rate in endometrial carcinoma.

(2) Most centers still practice pre-operative irradiation of the endometrium followed by wide panhysterectomy and removal of part of the vaginal cuff as the treatment of choice in endometrial carcinoma.

Acknowledgment is hereby made to my teacher, Solomon Weintraub, M.D., for his encouragement and allowing liberal use of our pathologic files.

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Traffic Safety Memo

In 1955, 37,800 Americans were killed in traffic accidents.

In 1955, 2,158,000 persons were injured in motor vehicle accidents.

Speeding on U.S. streets and highways last year killed 12,700 men, women and children.

Speeding on U. S. streets and highways injured 702,560 men, women and children.

In 1955, 8,130 pedestrians were killed in U. S. traffic accidents.

Weekend crashes accounted for 15,730 killed and 766,090 hurt during 1955.

More than 41 per cent of the deaths and more than 35 per cent of the injuries due to motor vehicle accidents last year occurred on Saturdays and Sundays.

Twenty-seven per cent of all drivers involved in fatal auto accidents in the U.S. last year were under 25 years of age.

Eighty-five per cent of the vehicles involved in accidents were passenger cars.

Three out of four traffic accidents happen in clear weather on dry roads.

Saturday is the most dangerous day of the week to drive.

Four to 8 p.m. are the most dangerous hours of the day to drive.

Excessive speed was the principal cause of traffic accidents in 1955.

More than 78 per cent of vehicles involved in fatal accidents in 1955 were traveling straight ahead.

Approximately 15,730 persons were killed in weekend traffic accidents last year.

More than 766,000 persons were injured in weekend traffic accidents last year.

The pedestrian record reflected the 5th consecutive year of improvement for motor vehicle accidents in 1955.

Jacob Bleiberg, M.D.

Newark

New Adjunct in the Treatment of Acne Vulgaris and Allied Conditions *

Acne is still with us. Atom bomb radiation scares have made many patients reject x-ray therapy. Dr. Bleiberg finds he can get good result with a sulfur-resorcinol-hexachlorophene preparation.

The treatment of acne vulgaris has long required a simple pleasant local application, without the risk of damage, which can be used as an adjunct by both sexes, in a not overly restrictive regime of therapy.

Acne vulgaris is seen primarily but not exclusively among adolescents. Some patients, and even many physicians take the position that acne is normal or physiological and that the patient will outgrow it without any need for active therapy. To the patient this attitude on the part of the parents and all too frequently on the part of the physician, is an additional frustration.

CAUSE

Constipation and menstrual derangements are listed as frequent concomitants and are implicated by many authorities as etiologic factors. Thyroid dysfunction, heredity and specific bacteria are also mentioned as related agents. At one time, it was felt that foci of infection could produce acne, and that the removal of infected teeth and tonsils would cure the disease. Nutritional factors were, and, by some, are still considered to be of great importance in the production of acne. Allergy, vitamin deficiencies, endocrine imbalance, sensitivity to halogens, hypercholesterolemia, poor hygiene and cosmetics are a few of the other theories which have had their day in the medical literature. Most of these theses have their champions even today. Psychosomatic factors are considered causative by some and capable of producing aggravation by many observers.

The multiplicity of etiologic theories has led to the distribution by physicians of a long list of "don'ts." These increase the emotional confusion of the patient. The entire question of acne therapy is in need of critical re-evaluation. The use of fractional x-ray dosage, which has been a mainstay of the dermatologist and the roentgenologist, is now being rejected, and possibly with justification, by wary patients. The impact of the atomic bomb, with its radioactive "fallout," does tend to make x-ray therapy seem more hazardous.

Hereditary factors, such as the "tendency to oily skin," must be considered. We must also weigh primary or secondary emotional disturbances which admittedly can result from the cosmetic aspect of the disease itself and which can be aggravated by long lists of "do's"

*This study was aided by a grant from the Desitin Chemical Company, Providence, R. I. Trade name for this preparation is Desitin Acne Cream, combining coloidal sulfur, resorcinol, zinc oxide and hexachlorophene in a flesh-tinted base.

and "don'ts." The young people who account for the greatest number of cases in this group are individuals who have attained maximum physical growth with all the urges and drives associated with this growth, but who have not yet had sufficient experience in living to cope with the situations and conflicts of adulthood.

PATHOLOGY

ALTHOUGH the etiologic premises are highly conjectural, the histology of the disease is well established. The changes vary only with the severity and duration of the eruption. The first lesion is the comedone. This is a plug of sebum which fills and dilates the follicle. Surrounding the follicle, but especially near the surface, there is a cellular infiltrate consisting principally of small round cells—at least in the early stage. The tissues surrounding the follicles are keratotic and edematous, thus narrowing the follicular orifice and preventing the discharge of sebum. Infection takes place in and around the follicle and it is the depth of this infection which determines whether or not scarring will occur.

TREATMENT

BECAUSE of the multiplicity of etiologic beliefs, the therapy of acne has become bewildering. Many of the agents used are of questionable safety. Current literature continues to report the non-selective administration of sex hormones locally and internally, even in patients who have no apparent endocrine abnormality. As a result, cases of gynecomastia in young males are being observed. X-ray therapy is being met with increased resistance by patients because of the fear of radiation over-exposure. In view of the mass fear engendered by an increasing public awareness of the effects of radiant energy in an atomic bomb era, the cautious physician hesitates to urge x-ray. One of the basic aims of treatment is to reduce rather than increase the emotional tension of the patient.

In selected cases, varied vitamins and vaccines may be of some value. Hygienic and nutritional measures are important, but should be presented unobtrusively, so that they do not appear tyranically restrictive.

Emotional factors, not incriminated as a basic cause of acne, must be considered as aggravating components. The patient, on self-examination, is disturbed by the appearance of his face and "picks" at it. His disease becomes the subject of anxious or derisive comment by his family and friends. All this makes the patient depressed, anxious and seclusive. This may clamp him on the merry-go-round of a vicious cycle. Emotional factors perpetuate or aggravate the pathology regardless of its basic cause. This may also help to explain the flare-up in girls just prior to the menstrual period. Pre-menstrual emotional tension is well-recognized. Pre-menstrual edema of the skin may also aggravate the inflammatory phase of the disease.

The troubled and confused patients who present themselves for treatment have generally already tried innumerable home remedies. They are upset by their failure to obtain improvement. When rapport has been established and the patients begin to talk more freely, they manifest tremendous resentment about the "do's" and "don'ts" which have been preached incessantly by their overanxious parents. Frustration and confusion thus perpetuate the clinical picture.

For these reasons it is considered important for the physician to have available for adjunctive acne therapy a simple preparation* which would be effective in treating, and which would conceal the lesions. Two of the oldest effective remedies in the local treatment of acne have been sulfur and resorcin. Their action is based on a keratolytic effect particularly at the follicular orifice. In addition, they reduce oiliness. The full therapeutic effect of these agents when used in combination is reached only when they produce fine desquamation. Of all the forms of sulfur, colloidal sulfur has long proved to be the most active in producing the desired effects. To reduce secondary infection of the comedone a bacteriocidal agent of low sensitizing index, as

hexachlorophene, is desirable. A mild astringent and soothing action, attainable with zinc oxide, was deemed advantageous. In addition, a cosmetically acceptable vehicle, free of grease and able to camouflage the comedones and pustules, was used. A small amount of pigment was incorporated to obviate the chalky appearance of many preparations used in acne. The pigment was kept to a minimum so that male patients could use it and avoid the "cosmetic look" and "mask-like" appearance accompanying "make-up" preparations.

This formula* was employed in 163 patients (42 males) with acne vulgaris. Ten of these patients are not included in the final tabulation because they did not return for follow-up observation. The patients ranged in age from 8 years to 45 years. There were 111 females, including 7 Negroes. All were instructed to rub the cream on the face twice daily. Those females who used make-up were told to use the cream as a make-up base. Make-up, except for greasy creams, was not interdicted.

Patients were observed for four months. Eleven patients, (7 per cent), experienced desquamation beyond the amount deemed necessary. These were then given a half-strength preparation. Eight were able to return, after a period of from 3 to 7 weeks, to the full strength formula without further irritation. Seventeen patients (11 per cent) found that they could attain the desired effect with only one application daily. Results of treatment were evaluated on the basis of the diminution of the number of comedones and pustules. On this basis 112 (73 per cent) showed marked improvement. This group felt that the use of the cream was the most important part of their treatment. Thirty patients (19 per cent) showed moderate improvement. Eleven patients (7 per cent) failed to show worthwhile improvement. Of this latter group there were eight severe cystic acnes. In no case was there any aggravation attributable to the use of the cream. There may have been sensitization in 5 of the 11 cases who were then treated with the half-strength cream with no ill effects.

*Resorcinol 2 per cent
Hexachlorophene ½ per cent
Zinc oxide 10 per cent
Colloidal sulfur 8 per cent

TABLE

Patients	Result	Ratio
112	Marked improvement	73%
30	Moderate improvement	20%
11	No improvement	7%
153	(42 males) (111 females)	100%

CONCLUSIONS

ACNE is a difficult problem for the physician. It is complicated by emotional factors and by increasing patient resistance to radiation therapy. Therefore, a safe form of topical therapy embodied in a greaseless cream, which blends well with light and dark skins so as to be almost invisible, is presented. It is applicable in both sexes and fulfills the essential quality of being completely and readily acceptable by the patient. It does not add to the existing emotional tensions of this patient group since it is pleasant, easy to use and does not create the obviously medicated or mask-like appearance.

31 Lincoln Park

Addiction Test

An eye test can help tell whether a person is a narcotic addict and even the extent to which he is addicted, reports Drs. James G. Terry and Fred L. Brammoeller of the Santa Rita Rehabilitation Center, Pleasanton, California, in *California Medicine*. The person takes a safe dose of nalorphine. The diameter of the eye pupil decreases if he has not been using opiates or increases if he has.—*Today's Health*, April, 1957.

William A. Halbeisen, M.D.

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Camden

Quinidine Thrombocytopenic Purpura

A Case Report*

We are reminded that quinidine may induce a severe purpura, and that it responds dramatically to ACTH. The authors warn against administering quinidine as a well-meant but hazardous therapeutic test. Platelet agglutination studies will confirm the diagnosis safely.

Thrombocytopenic states have been induced in patients by a wide variety of drugs. Some of these such as benzol, aminopterin and related compounds, chloramphenicol, gold, and triethylenemelamine, act directly upon the megakaryocyte by destroying them in large numbers. Other drugs, like quinine, quinidine and Sedormid® act indirectly by destroying the circulating platelets and inhibiting platelet formation through an abnormal immunologic mechanism.

Quinidine thrombocytopenic purpura has recently assumed importance because its immunologic reaction is better understood. It can be reproduced *in vitro* and it helps to explain the mechanism in some patients with idiopathic thrombocytopenia.

This form of purpura was first described by Broch [1] in 1941. Not until 1947, when Soisalo [2] reported a similar patient, did a report of quinidine thrombocytopenia appear in the literature. Since then a number of cases have been reported. Recently Fulton and Dameshek documented 23 cases and added five of their own.[3]

The development of this type of purpura requires previous sensitization to quinidine. Subsequent administration of the drug, even in exceedingly small doses, results in the sudden development of thrombocytopenia. Epistaxis and bleeding of the gums often herald the attack. The process then becomes widely disseminated affecting particularly the limbs. Hematemesis, melena, hematuria and vaginal bleeding may occur. Bullous hemorrhagic lesions may develop in the mucous membranes and skin. The disease subsides spontaneously upon the withdrawal of quinidine.

CASE REPORT

A 43-year old white housewife was admitted to Our Lady of Lourdes Hospital because of the sudden development of "blood nodules" on the tongue

*From Our Lady of Lourdes Hospital, Camden, N. J.

1. Broch, O. J.: Nord. Med. 10:1542 (May 17, 1941)

2. Soisalo, Pasquale: Annales medicines internales Fennial. 36:181 (April 1947)

3. Fulton, F. G. and Dameshek, W.: *Blood*, 11:527 (July 1956)

and skin beginning at 4:00 p.m. on the day of admission. These nodules quickly increased in number and severity. The patient stated that, at 9:00 a.m. on the same day, she had headache and "felt completely washed out." She visited her physician at 10.45 a.m. She was found to have tachycardia. She was given quinidine, grains 3, every 4 hours and was sent home to bed. She took this medication until 10:00 p.m., a total of three doses.

She had suffered from palpitations of the heart for 4 or 5 years. These palpitations were gradually increasing in number. She had been hospitalized and was told that she was free of heart disease and that her symptoms were due to a "nervous condition." The patient had periodically received quinidine in the past for her palpitations. Her past medical history was otherwise, essentially negative. Family history revealed maternal hypertension, fraternal rheumatic fever and a sister who had a "nervous heart with spasms" and exhaustion.

On admission to our hospital, this patient presented the symptom of purpura. The lesions were particularly noticeable about the face, mouth and extremities. There was a large, gelatinous, bullous hemorrhage on the right margin of her tongue. It was one centimeter wide. The lesions on the extremities were deep seated and dark. The patient had a cough and was expectorating bright red blood. Speech was thick and she was moderately drowsy. She wore a hearing aid for middle ear deafness. Eye ground examination was negative. There was a faint systolic murmur at the apex which appeared to be of an evanescent type, varying with respiration. Blood pressure was normal at all times. There were bilateral basal rales. The liver and spleen were not palpable. There were no abnormal neurologic signs. X-ray examination of the chest and cardiac fluoroscopy were negative. The electrocardiogram was not specific. Psychiatric evaluation revealed a severe chronic anxiety state with some depression.

Red blood count on admission 2,800,000 and on discharge 4,500,000. White blood count on admission was 3000 and on discharge was 10,700. Bleeding time was over 30 minutes on admission and 4½ minutes on discharge. The platelet count was 14,000 on admission and 194,000 on discharge. Prothrombin time was 100 per cent. Urinalysis was negative. Serologic test for syphilis was negative. B.U.N. was 14 and the blood sugar was 103. There was no clot retraction on admission. On discharge the clot began to retract in 1 hour and was complete in 24 hours. Stool was negative for occult blood. Sedimentation rate was one millimeter in one hour. The hematocrit was 35 per cent. The mean corpuscular volume was 103 cu. microns. Coombs test was negative.

Bone marrow aspiration the day after admission showed a slight decrease in the number of megakaryocytes. Most megakaryocytes were of the intermediate type. The few mature megakaryocytes were abnormal. They lacked the granularity of the cytoplasm, had no platelets surrounding them, or were degenerating. There was an absence of platelets.

The aspiration was repeated shortly before discharge. There were then a normal number of megakaryocytes that were mature. They showed granularity of the cytoplasm and large clumps of platelets at their margins. Platelets were abundant throughout the smears.

As soon as the diagnosis was suspected, the patient was given 25 milligrams of ACTH intravenously in a slow eight hour drip. This was repeated daily for the following 2 days and the patient thereafter was given Prednisone, 5 milligrams four times a day until discharge. During her stay in the hospital she received 2,250 cubic centimeters of compatible blood. On discharge, she was given Prednisone, 5 milligrams, twice a day with instructions to the referring physician gradually to discontinue the drug.

The response of this patient to intravenous ACTH, was dramatic. Within 13 hours, the lesion on the tongue had almost completely disappeared and the other lesions began to subside. No new lesion appeared after the beginning of steroid therapy. At no time during her hospitalization was there any unusual temperature response. Because of the depression of the leucocytes and the hemoptysis, she was given 300,000 units of procaine penicillin twice a day for several days. The drug was stopped after her clinical course became better.

Platelet agglutinanion tests for quinidine done on her serum shortly after discharge were negative. She has been followed by the family physician and was examined by one of us a year later. She has had no subsequent bouts of purpura.

Ackroyd [4] was the first to describe the abnormal immunologic mechanism produced by drugs that precipitate thrombocytopenia as an allergic response. He observed a marked *in-vitro* agglutination of platelets from a Sedormid®-sensitive patient in the presence of this drug, and subsequent platelet lysis and reduced clot retraction. An abnormal factor in the patient's plasma was essential for platelet agglutinations and lysis by the Sedormid®. The factor was active against both normal platelets and the patient's platelets while the patient's platelets were unaffected by the drug when suspended in normal plasma. These observations suggested that Sedormid®-induced thrombocytopenia was preceded by an *in-vivo* platelet agglutination and lysis. Ackroyd [4] further observed that a local patch test of a suspension of Sedormid® crystals in a saturated solution in propylene glycol induced purpura to the affected area only.

These *in-vitro* tests are now well established and are described in detail by Fulton and Dameshek.[3] They can be carried out in the hospital laboratory and should be used to determine the etiology of the various drug-induced purpuras. It was felt that the platelet

agglutination test was negative in the patient reported by us because the acute phase had passed and the patient was still receiving steroids. The agglutination test, on the other hand may remain positive for months. The further use of agglutination tests will undoubtedly help to eliminate the adjective "idiopathic" from the diagnosis of many patients with thrombocytopenic purpura.

Although it is known that patients with quinidine thrombocytopenia will have a spontaneous recovery when the quinidine is discontinued, the dramatic results with ACTH warrant its use in the acute phase. Absolute bed rest and the administration of transfusions are also helpful. Splenectomy is contraindicated.

When purpura develops acutely in an adult, the possibility of drug sensitization should always be considered.

Once the diagnosis is suspected, a therapeutic trial with quinidine should never be attempted. Larson[5] tried to "prove" the diagnosis in his patient with frightening results. The intradermal test is as risky as the oral route. He was unable to confirm the diagnosis with the patch test described by Ackroyd.[4]

The safest and most reliable technic for establishing the diagnosis is the platelet agglutination test.

SUMMARY

A PATIENT with quinidine-induced thrombocytopenic purpura is described. The changes in the bone marrow are helpful in confirming the diagnosis. Quinidine, like quinine and Sedormid® may induce a severe thrombocytopenia by producing an abnormal immunologic response that can be demonstrated *in vitro*. The treatment is absolute bed rest, ACTH, transfusions and withdrawal of the sensitizing drug. Drug sensitization should be considered when acute thrombocytopenic purpura develops in the adult. Once the diagnosis is suspected, a therapeutic test dose with quinidine is too dangerous to try. The diagnosis can be confirmed safely and accurately by platelet agglutination studies.

4. Ackroyd, J. F.: American Journal of Medicine, 14:605 (August 1953)

5. Larson, R. K.: *Blood*, 8:16 (January 1953)

1600 Haddon Avenue

Physicians Live Longer

Except in the 60 to 70 age bracket, physicians live longer than other persons. In the 1949-1951 biennium, for instance, Dickinson* found 7 per cent fewer deaths than would have been expected among a comparable non-physician population. It was calculated that there were 204,450 physicians on record in a 1950 census of the doctor population. In 1949-51, there were 10,738 physician deaths. This was only 93 per cent of the number expected, based on figures for the white male population in general.

Life expectancy for physicians was better at almost every age level than it was for other men. For instance, at age 25 the physician could expect to live a year longer than other 25-year old men.

However, heart disease and diabetes hit physicians harder than other men. Diabetes took 35 per cent more deaths than would have been expected, while heart disease took two per cent more. This was especially important after the age of 60, and probably explains why the age groups 60-69 were the only groups which had higher death rates than the rest of the male non-physician population.

*Journal of the American Medical Association, Dec. 15, 1956.

Lester Weissman, M.D
Alfred Margolis, M.D
Newark

Agranulocytosis Following Chlorpromazine

The trouble with tranquilizing drugs is that they may tranquilize the doctor as well as the patient. And thus, at ease, the physician may fail to note untoward effects. Here is a simple case report high-lighting one of the commoner side-effects of chlorpromazine.

In the transition from the "Aspirin age" to the "Tranquilizer age" a multitude of new drugs have become available for the treatment of psychosomatic problems. As the list increases, so must our awareness of certain changes following use of these drugs. We present a brief clinical note demonstrating one of the pitfalls encountered in the use of one of the more popular drugs, chlorpromazine.

A 62-year old woman has been under treatment for a multitude of vague and inconstant disturbances, most of which were of emotional origin. In 1934 a cholecystostomy had been done with the removal of a large stone and drainage of the gall bladder. For several years, she manifested a fluctuating hypertension and received rauwolfia alkaloids.

In April 1956, she felt severe chest pains requiring narcotics and hospitalization. On admission, her blood pressure was 210/100. The patient was a markedly obese female with no other abnormal findings on physical examination. Electrocardiogram was within normal limits. X-ray showed a normally functioning gall bladder. A complete blood count, differential, sedimentation rate, blood urea nitrogen and blood sugar were normal. While in the hospital she began to vomit and chlorpromazine 25 milligrams, was prescribed four times daily. She exhibited a marked improvement in her general outlook and the symptoms all subsided. She was discharged. Because of the marked improvement she was continued on chlorpromazine at home. Two weeks prior to her most recent hospitalization, the dose was increased to 50 milligrams four times a day.

In September 1956 she developed a high fever and sore throat. The pharynx was markedly injected and multiple non-suppurative inflammatory areas were found in the groin, in the vulva and thighs and the left axilla. She was treated at home with penicillin and Achromycin® without response and again hospitalized. On admission she appeared toxic. Admission temperature was 105. The pharynx was beefy red without exudate. Anterior cervical adenopathy was present. Heart and lungs were negative. Blood pressure was 180/100. Inflammatory areas were present on the vulva, left groin and left axilla. Combiotic®, chlorpromazine, wet dressings and Chloromycetin® were ordered on admission. The next day, we found non-hemolytic streptococci and staphylococci in the throat culture. The white blood count dropped to 1800 with 94 per cent lymphocytes.

On receiving this report we stopped all medication. Penicillin 600,000 units, every four hours and Streptomycin® 5 Grams, twice a day were ordered. From this point she showed continual improvement with temperature subsiding. The area in the left axilla developed a gangrenous slough which required surgical drainage, after which the patient made an uneventful recovery. The table shows the follow-up white counts and differentials.

TABLE

October	White Cells	Myeloblasts	Stab Forms	Segmented	Lymphocytes	Mono.
2	1,950	3	14	2	78	3
3	3,500	4	7	7	74	8
4	4,600	7	13	5	62	3
5	5,560	8	16	16	44	15
6	12,000	2	14	54	12	8
8	13,500	0	5	66	29	0
12	12,600	0	0	67	33	0

There can be no doubt as to the etiology of the agranulocytosis produced in this case. This is not meant to detract from the usefulness of the drug. We wish merely to point out one of the dangers in the use of a drug now commonly prescribed. While the reaction described in this report is infrequent, proper safeguards against agranulocytosis must be taken. This means frequent counts and the use of such drugs only when the indications are clear cut.

The treatment of agranulocytosis consists simply of removing the offender and maintaining the patient on appropriate antibiotics until intrinsic body defenses are restored. There is no effective way of stimulating granulocyte formation. As can be seen from our case, restoration is rapid when the offending depressant is removed.

In this case watchful expectancy and antibiotic support resulted in an uneventful recovery.

736 Sandford Avenue

Cost of Medical Care

When the various parts that go into the nation's health bill each year are added up, the total is staggering. Estimates of private and public spending include the cost of everything from patent medicine and toothpaste to surgeons' fees. In 1956, private care for the country was placed at $11.2 billion, while public care (federal, state and local) was estimated at $3.9 billion. The following figures for private care costs are for 1956.

$3.4 billion for physicians' charges.
$3.7 billion for hospital charges.
$2.3 billion for charges for drugs and appliances.
$1.8 billion for other charges, including nursing, etc.

HEALTH AND MEDICAL RESOURCES

The medical "plant" that provides the country with the finest care of any nation is impressive. In one area, that of medical school graduates, bare statistics fail to tell the whole story. They do not, for instance, reflect the increased utilization of physicians' skills and the advance of medical knowledge in treatment of patients.

225,579 physicians in U. S. in January 1957.
1,604,000 hospital beds in U. S. in 1956.
430,000 professional nurses in 1956.
300,000 practical nurses, attendants, and aides in 1956
4,735 medical school graduates in 1930.
5,275 medical school graduates in 1940.
6,135 medical school graduates in 1950.
6,845 medical school graduates in 1956.

VOLUNTARY HEALTH INSURANCE

One development of great importance in furnishing medical care has been the growth of voluntary health insurance. Twenty years ago the number of persons covered by some form of health insurance was only 1.5 million. When the drive was on for compulsory health insurance in 1949, just over 50 million persons were covered by voluntary insurance. Organized medicine contended then that voluntary coverage would expand, thus obviating the need for government insurance. The figures below indicate this was a good estimate of the situation.

110,000,000 persons now covered for hospital charges.
92,000,000 persons now covered for physicians' charges for surgery.
55,000,000 persons now covered for physicians' medical charges in hospitals.
10,000,000 persons now covered for physicians' home and office call charges.
10,000,000 persons now covered for major medical expenses (catastrophic) compared with 1,200,000 covered in 1953.

Historical Article • • •

HENRY A. DAVIDSON, M.D.
Cedar Grove

New Jersey and the Great Pandemic

Thirty-nine years ago this month the greatest holocaust in American medical history reached the United States. Here is a personal and somewhat informal view of the great influenza pandemic as seen in New Jersey.

ON SEPTEMBER 25, 1918, Dr. Morton Brotman reported "Spanish Influenza" in a family on Bedford Street, Newark. This was the first reported civilian case in New Jersey. It was not the last. In less than 100 days, the disease was to kill 12,000 civilians in our state.

The influenza pandemic of 1918 was the greatest medical holocaust in history. In the United States it killed half a million people. Across the globe, within a 20-week period, influenza wiped out one per cent of the earth's population. Maybe in a few countries, the black death had a higher death rate in its time. No one knows. But no other scourge ever slaughtered twenty million people in one season. And that's what influenza did in 1918.

And yet, this pandemic caused practically no panic. It inspired no poetry, no art. It never developed a mythology. It caused less public excitement than finding a leper in New York (leprosy is a far less dangerous disease) and infinitely less reaction than a mythical invasion from Mars.

There was some concern, and the usual battery of old wives' tales; but by and large, the interest of the people was focused elsewhere. It was focused on what was innocently called "The Great War." It was focused on draft dodger raids, on efforts to break the Hindenburg Line, and on the death of a beautiful dream in Russia. The war itself seemed so much more deadly than any disease could be. But this was wrong. Our country suffered 53,000 combat deaths in World War I. But we buried 530,000 victims of influenza. The pandemic was ten times as fatal as the "Great War."

Where did it all start? The explanation at that time was that it started in Spain, moved to France, infected the troops at the front, and was carried by them, in transports back to the U.S.A. Hence the name "Spanish influenza." Hare,[1] however, believes that it started in the traditional reservoir of influenza: Asia. Others say that Chinese coolies brought it into France—coolies hired to replace the dwindling French manpower. Hare[1] puts it this way:

> "In 1918 as the old Somme battlefields were being crossed, and as the Hindenburg line loomed through the mists of early autumn, something infinitely more sinister made its appearance. This was a lethal influenza. It was present in Chungking in July (1918), in Persia early in August and in Brest, France, by the middle of August. Australia, remote in the southern seas was able to avert the peril for a time. But the disease broke through in February 1919."

1 Hare, Ronald: Pomp and Pestilence. New York 1955. The Philosophical Library.

2 Journal of the American Medical Association, September 28, 1918.

The first case in the United States[2] was reported from Boston on August 28, 1918. A sailor, on a transport being tied up to a Boston dock that day, had symptoms of influenza. It infected New England like a forest fire. In Massachusetts alone it killed 15,000 civilians in four months, plus an unknown number of others whose deaths were erroneously classed as "pneumonia," "encephalitis," "meningitis" or masked under other rubrics. The invasion struck along two prongs: civilian and military. Some of the sailors on the first Boston shipment were transferred to Michigan and Illinois and became nuclei for the spread of influenza in the midwest. Soldiers being returned from Europe carried the disease to Fort Dix where the first case[3] was reported on September 22, 1918.

IT WAS felling people in Massachusetts during the first week in September; it swept through Connecticut during the second week and reached the Bronx by the third week of the month. It leaped the Hudson, and laid low many in northern New Jersey who were not listed because the disease was not made reportable until late in the month. By September 25, the records of the Newark Board of Health officially showed the first New Jersey civilian case. It had appeared at Dix, however, a few days earlier.[3]

Richard Pfeiffer believed that the *Hemophilus influenzae* (which he had discovered and named in 1892) was the cause of the disease. Early in the 1918 pandemic, this was general medical opinion, the organism being then called "The Pfeiffer Bacillus." However, the bacillus did not meet the postulates for causal relationship, and the bacillus theory is now generally discarded. Most authorities believe it is—and was—due to a virus.

In 1918 the disease was seen chiefly in its pneumonic form, which is clinically described by Freund[4] as follows:

> "The onset is sudden and violent. There is chill, fever, headache, pain in the back and legs and a sense of intense prostration. There is probably no disease in which the initial symptoms are more violent. Victims are literally stricken down in their tracks. Individuals at work are utterly overcome. Mental symptoms are seen in all grades from torpor to mania. The patient looks prostrated. The face is suffused and may be cyanotic. Eyes are red and swollen. The skin is dusky. The lips are thick."

The most dramatic feature was the abruptness of the onset, and the way in which it galloped. Writing about it in this JOURNAL, Willan[5] said: "It was a common occurrence for me to be in conversation with a man in his usual health; and in less than 5 days meet him on the autopsy table."

The epidemic did not attract much attention in New Jersey until rather late in September. I was unable to find a single reference to it in any issue of the Newark *News* until September 25, when a story was headlined: "Center of trouble is New England. Here it has already passed its peak." This was a bad guess. The crest was not reached until the end of October. In one day in Newark, on October 26, there were 79 influenza deaths. In that week, Newark suffered 400 deaths from influenza—*in one week*, in a city with 300,000 people. The Trenton *Times* was concerned because of the raging epidemic at nearby Fort Dix. But this paper's first reference to influenza was a humorous one. On September 12, 1918, the Trenton *Times* carried an editorial teasing New York Health Commissioner, Dr. Royal S. Copeland, for his advice to kiss only through handkerchiefs in order to prevent spread of the disease. On September 18, the Trenton *Times* gave the illness more sober treatment. The headline was "Influenza Killing 70 a Day in Boston." Two days later, the *Times* carried the curious boast: "Influenza at Dix now reduced to 791." That was September 20. On September 28, the heading was "Dix Epidemic Still Rages." And on October 5, the news in Trenton was that the whole city was to be quarantined—trolley cars were to be avoided, churches, theatres, movie houses, schools, even saloons, were to be closed.

3. JOURNAL of The Medical Society of New Jersey. November 1918. Page 399.

4. Freund, Hugo: "Influenza;" chapter in Tice: "Practice of Medicine." 1927. Hagerstown, Maryland.

5. Willan, Edward H.: JOURNAL of The Medical Society of New Jersey. October 1919. Page 363.

The closing of the saloons was a heroic measure that was resisted in some cities. In one large city, the mayor cancelled the health officer's order closing saloons. Nothing in the city charter, he said, gave the health officer any such power. In another city, the mayor ordered the saloons re-opened because doctors considered whiskey a sovereign treatment for the disease, and therefore, he argued, the saloon must be the healthiest place in town.

On September 26 the Newark *News* headline was "Newark Ready if Influenza Breaks Out." Mayor Gillen organized a panel of physicians to advise on how to prevent or curb the invasion. Dr. Craster published an assurance that accommodations at the Newark City Hospital were adequate — and certainly this hospital did extend itself to admit all comers. At one time, indeed, they rented an empty Ludwig Baumann furniture warehouse and set up extra beds there.[6] Not all hospitals were so ready, however. Thus in the September 28 Trenton *Times*, there was the story of a hospital which refused to admit an influenza victim in order "to protect the other patients."

Many schemes were proposed for putting up a barrier to infection. Stretching canvas or other sheets, between beds,[7] for example was a highly recommended procedure. Also recommended was hourly throat spraying, disinfectant tooth paste, boiling of eating utensils, and the administration of whiskey. The distinguished American internist, Lambert,[8] reported that he had cut the mortality rate by a regime consisting of heroin, tepid sponging, belladonna, gelsemium, and whiskey. There was much call for opiates because of the severe backache and headache associated with the disease. The Federal Government relaxed its restrictions somewhat, permitting re-order of opiates without a new prescription.[9] The Newark Evening *News* commented editorially on this as follows:

> The announcement that the federal authorities at Washington have modified the enforcement of the law governing the dispensing of narcotic drugs means that, to some degree, the work of the overtired physicians will be lightened during the continuance of the epidemic conditions. The modified order permits prescriptions that contain morphine, codeine or heroin as ingredients to be renewed on the doctor's original order as frequently as may be required. It might have been issued with beneficial results before now, but it will be a boon both to the physicians and sufferers as long as influenza continues to be a public menace.
>
> It has been found a hardship to comply with the law that requires a new prescription to be issued every time medicine is needed. The doctors of all afflicted cities are being taxed as never before in their efforts to salvage endangered lives. They have been kept so busy that it has been impossible for them to hold themselves available at all times for writing new prescriptions.

The Trenton *Times*, in its September 27 issue, published a box on page 1 captioned "Influenza Preventative." This was an instruction to wet the hand with camphor and inhale the fumes. Many people wore bags around the neck. Some bags contained camphor, some held asafetida, and others contained amulets and charms.

The most popular prophylactic device was the face mask. In a recent (June 1956) issue, the *American Legion Magazine*, in a reminiscent article by Tom Mahoney, published photographs of ball-players wearing masks while engaged in active play. There is also a picture of a squad of marching troops, fully accoutred, looking like space cadets because of their masks.

The efficacy of the mask was doubted in many quarters, but the custom persisted during October and November because it was a symbol of "doing something." Freund[4] said the masks were simply dirt traps. A "positive menace" he called them.

Since there was no test for influenza, it was impossible to be sure of the diagnosis—particularly in mild cases. The statistical error was in the direction of overestimating the morbidity and underestimating the mortality.

6. Personal communication, May 1, 1957, from Edwin Steiner, M.D.

7. November 1918 Journal of The Medical Society of New Jersey, Page 399.

8. Lambert, S. W.: American Journal of The Medical Sciences, 157:849 (December 1919).

9. Journal of The Medical Society of New Jersey, February 1919, Page 66. Reprinting an editorial from the Newark (N.J.) Evening *News*.

Some doctors called every cold "influenza," and in times of epidemic, it is hard to prove that they were wrong. This made morbidity seem higher than it was. On the other hand, a spuriously high incidence rate would necessarily lead to a spuriously low fatality rate. If of 100 certain cases, 7 died, the true mortality would be 7 per cent. But if the statistics showed 200 cases (100 of which were ordinary colds) then the mortality rate would appear to be 7 in 200 or 3½ per cent. Thus the actual mortality rate is always an understatement. In New Jersey the published rate was about 7 per cent. However, this is subject not only to the error just described, but to the added error of classifying some influenza deaths as pneumonia, encephalitis or meningitis. It can be said only that the mortality rate from this disease was more than 7 per 100 stricken.

I DEVELOPED influenza myself as I was preparing for a Halloween party on October 30, 1918. I was 13½ years old. My father was a busy practitioner. Throughout October he had been ministering day and night to the needs of his patients, but finally, he collapsed too.

So my mother called on our good family friend, Dr. Nathaniel Price, to attend us—to attend me, rather. My father insisted on treating himself. Dr. Price believed in bed rest plus whiskey as the ideal treatment for influenza. My father, on the other hand, preferred to treat each symptom as it came up—a laxative for the constipation, a sedative for the excitement, an expectorant for the cough, a tonic for the weakness and an anodyne for the pain. At 13½ I was in no position to disapprove of my father's polypharmacy, but by the time I had finished third year medical school, I could lecture to him severely on what was wrong with his methods of practice. At 13½, however, I preferred my father's wondrous technic to the oversimplified regime prescribed by Dr. Price. There was another factor too. In 1918 there was much agitation for the outlawing of whiskey. Prohibition was on its way. The papers carried stories of merchants sent to jail for selling liquor to soldiers. Since the sixth grade, I had been barraged with anti-whiskey propaganda. By then, I was convinced. So the whiskey which Dr. Price wanted me to take as medicine, struck me as an evil potion indeed. My poor mother, who had to nurse both of us and get Gordon off to school every day had enough troubles without engaging in arguments on the morals of alcoholism. At any rate, she and Dr. Price between them managed to get the *spiritus frumenti* down my unwilling throat. I have detested the stuff ever since.

The word "influenza" is the Italian for "influence:" *Influenza de freddo* (influence of the cold) describing the disease and its presumed etiology. It is also possible that the many epidemics of the disease which harassed Europe periodically for millenia, have been ascribed to acts of God, hence "influence" in that sense. The alternate name for the disease "La Grippe" is from the French *agripper* (to seize) and refers to the sudden seizure of illness.

MANY observers commented on the fact that the strong seemed to succumb more readily than the weak. Mr. Morgan of the Newark Health Department [10] for instance remembers that at Camp Dix "the Sandstorm Division—cowboys from Arizona and New Mexico—were dying like flies. The pale face ghetto boys from Brooklyn and New York had a far lower case fatality." Mr. Morgan also recalls that "cemeteries had great difficulty in storing bodies. There were insufficient grave diggers to effect burial." This last gruesome note is repeated throughout many of the contemporary accounts of the pandemic. The reason for the greater sensitivity of the strong was never adequately developed—or for that matter, was not really statistically validated. Dr. Haskin [10] suggests that it is related to respiratory resistance, which, presumably would have been developed better in slum areas than in wide open spaces.

To get some idea of the extent and fatality

10. Personal communication from Aaron H Haskin, M.D., dated April 23, 1957.

of this epidemic compare New Jersey's influenza deaths during the last three months of 1917 and during the last three months of 1918: the figures are 110 deaths and 11,829 respectively: These are deaths, not cases.

A look at the 10 commonest causes of death in 1918 and at the 10 commonest causes in 1956 is interesting. Here are the 10 leaders for 1918. The numeral indicates deaths per 100,000 population.

400—Influenza
244—Pneumonia
214—Cardiovascular disease
168—Early infancy
156—Tuberculosis
137—Other respiratory diseases
121—Kidney diseases
107—Accidents
87—Cancer
69—Digestive diseases (adults)

The "early infancy" item is made up of "diarrhea in children" with a death rate of 74 and a classification of "other diseases of early infancy" with a death rate of 94 per 100,000. (That's per 100,000 general population not per 100,000 infants). I do not know what the "other diseases of early infancy" were—prematurity perhaps, or "marasmus." Cancer was number 9 on the list—today it is number 2. The ten leading causes of death today include suicide, diabetes, and liver diseases. Actually these have not increased. It is simply that so many more deaths are now bunched in the first and second place (cardiovascular and cancer) that the other 8 rates, no matter how small, entitle them to place among the first ten. In New Jersey today the ten commonest causes with rates per 100,000 are:

590—Cardiovascular diseases
187—Cancer
12—Accidents
38—Immaturity and congenital
29—Pneumonia
22—Diabetes
17—Liver disease
12—Suicide
11—Kidney disease
10—Tuberculosis

While accidents have jumped from eighth to third position, the actual death rate from accidents has declined from 107 to 42. The death rate from diabetes has tumbled from 52 to 22; but because of the disappearance of some of the 1918 causes, diabetes now appears as the sixth major cause of death, whereas it did not place at all in the top ten in 1918. With a general death rate of 1051 per 100,000 in New Jersey today, the two prime causes (cancer and cardiovascular) account for 777 out of the 1051, so that the remaining 274 cases (per hundred thousand) have to be distributed among a hundred other causes.

Reporters everywhere were impressed with the speed of spread of influenza. The incubation was worked out as 24 to 72 hours and the speed of transmission was that speed of human movement. In Asia the disease moved at the pace of galloping horses. In the western world it moved with the trains.

Our predecessor, Dr. David C. English,[11] who edited this JOURNAL at that time, commented on the efforts of the various health departments to check the spread of the disease by banning public assemblies. The State Health Department here wanted to forbid all public gatherings—churches, schools, movies, saloons, sporting events. Dr. English[11] then added:

> The New York City Health Department took a more moderate course which is said to have been endorsed by such eminent authorities as Drs. C. V. Chapin, M. J. Rosenau, W. H. Welch, V. C. Vaughn. The schools were not closed and a discriminating attitude was adopted in closing theatres, moving picture shows and other places of public gatherings in large numbers; those places being closed that were found on inspection to violate sanitary laws or to be favorable to the breeding of disease. Dr. R. S. Copeland, the city's Commissioner of Health, in a public address said: "It required courage to assume such an attitude in the face of opinion which is not based upon authority or study. It is worthy of note that the cities which enforced the most rigid closing orders for theatres, schools, churches and other places of public assembly failed to experience any marked reduction in the prevalence of this disease, except in one or two instances where the closing order went into effect at or about the time when the decrease was unrelated to any activity of the health department of those cities."

11. Editorial in the November 1918 JOURNAL of The Medical Society of New Jersey.

The epidemic did not reach page 1 of the Newark *News* until September 27 when the paper ran comments from various physicians. Dr. H. H. Satchwell, physician at the Newark shipyards, reported a burgeoning epidemic there. Dr. Julius Levy of the Newark Health Department, then—as now—a dedicated advocate of health education, said: "This outbreak comes at a time to give impetus to public health education." Dr. Charles Craster warned against kissing and Dr. M. J. Fine warned against shaking hands. You might touch your mouth and transmit the bug.

In terms of deaths per thousand of population (not per thousand of persons stricken) the death rate was 4 in the United States, 23 in Mexico and 40 in India.

At that time New Jersey's Health Department had little executive authority. The policy-executing agency was a "Board," and the director was an administrative official. Mr. Moses Baker,[12] a Montclair civil engineer and former member of the State Board of Health took the epidemic as an expression of the need for firmer leadership in the State Health Department. "The efficiency of the Department would be greatly increased" said Mr. Baker,[12] "if the Board were swept out of existence, and all executive functions concentrated in a single Commissioner." It took 30 more years, but we finally made it in New Jersey.

There is a curious relationship between influenza, 1918 and epidemic encephalitis. When I was doing graduate work in neurology in 1929, we were told that the "so-called influenza epidemic of 1918" was really an epidemic of encephalitis. We saw many cases of parkinsonism in young men in our clinics at the Graduate Hospital in Philadelphia and at the Philadelphia Orthopedic Hospital* in those days. The patients did not have enough arteriosclerosis—indeed were too young — to account for the paralysis agitans on the traditional vascular basis. So, presumably, they had a post-encephalitic parkinsonism. However, their history was that they had had influenza in 1918. Dr. Weisenburg and the rest of his staff in that period (1929 and 1930) taught that encephalitis masqueraded as influenza. And I had no reason to disbelieve them. As far back as 1920, Dr. Horsford[13] in this JOURNAL described a case of lethargic encephalitis associated with influenza and speculated as to the possible relationship. Delirium was a common symptom of influenza and it is hard to say whether it was a toxic delirium or whether the patient really had "brain fever." Since my own private practice between 1931 and 1942 was limited entirely to neurology and psychiatry, I had no occasion to see any of the sequelae except the neurologic ones, and I accept as an article of faith what they had taught me in Philadelphia: that it wasn't a pneumonic process at all: it was encephalitis.

BUT it wasn't. In 1942 the Matheson Commission's report[14] was published. At that time I was otherwise occupied in Australia and New Guinea and I did not see this work until my return. The studies by Neal and her collaborators[14] made it clear that encephalitis and influenza were two different diseases. Part of the confusion was due to the fact that the two illnesses were coincidentally prevalent in the 1917-1919 biennium. Part of the confusion was due to the fact that the early symptoms of mild encephalitis could resemble an attack of 'la grippe." However, Neal[14] showed that the influenza virus was not neurotropic and could not have been the pathogen responsible for encephalitis. The psychiatric manifestations of influenza were real enough, but they were toxic, not encephalitic phenomena. This rejected Smith Ely Jelliffe's earlier observation[15] about influenza. In this connection, Jelliffe[15] said: "There is probably no other acute infectious disease (other than in-

12. JOURNAL of The Medical Society of New Jersey, January 1919, Page 4.

13. Horsford, Frederick G.: JOURNAL of The Medical Society of New Jersey, April 1920.

14. Neal, Josephine: *Encephalitis*. New York 1942. Grune and Stratton.

15. Jelliffe, Smith Ely: New York Medical Journal, 108:725 (December 1918).

*Don't let this title confuse you. The Orthopedic Hospital was then a neurological institution. Retaining an ancient name is an ancient Philadelphia custom.

fluenza, that is) which gives rise to so many diversified types of mental disturbance ranging from the simplest fatigue to a severe defect which may, at a single blow, wipe out the entire mental life." Dr. Jelliffe was actually describing encephalitis which was sporadic in the United States in 1917 and 1918. He was not describing influenza except in so far as some of its toxic phenomena might have come under the "simple fatigue" category.

Can it ever happen again?

We have vaccines today and vaccinated soldiers in World War II largely escaped influenza. Not entirely though. About 2¼ per cent of the vaccinated soldiers *did* contract the disease.[16] Among the unvaccinated the score was 7 per cent. But there are always new types and strains of the virus. Vaccines sometimes evoke a more hardy virus, too.

Chemotherapy and antibiotics ought to reduce infectious and pneumonic complications, but there is no evidence that these drugs will kill the virus or stop the influenza.

On the other hand, the world is becoming more crowded, and transportation is swifter than it ever was. So if the scourge gets a toehold, the next epidemic will move fast. Of this as of much else, famous last words include the phrase "It can't happen again and it can't happen here."[17]

P. O. Box 500

Who Gets Headache?

An educated, unmarried woman under 20 years of age is likely to be the most frequent user of aspirin tablets. Farmers are the least susceptible to recurring headaches, according to a survey* of the causes and distribution of mankind's most prevalent complaint. People who are divorced or separated are more apt to have headaches than married folks.

Ogden* noted that all headaches are characterized by disturbance of the blood vessels. In most varieties the pain can be relieved by the use of straight aspirin.

More than 80 per cent of medical students questioned were found to complain of headaches. Business executives were second, 77 per cent being victims, followed by professional people, 70 per cent; housewives, 69; clerks, 68; salesmen, 58; manual laborers, 55, and farmers, 50 per cent.

People with little education are less likely to be affected. Other findings: 71 per cent of women suffered, compared with 50 per cent of men; 71 per cent of the unmarried and 61 per cent of married persons had headaches, while 69 per cent of separated mates and 68.5 per cent of the divorced had attacks.

Ogden* lists some immediate causes of headaches as fatigue, hunger, sexual tension, allergic reactions, acute nasal trouble and excessive smoking. Factors predisposing to blood vessel disturbances include endocrine conditions, sex tensions, heredity, high blood pressure, allergies, stress, anxiety, and injuries of the upper spine.

16. Mahoney, Tom: American Legion Magazine, June 1956. Page 60.

17. It's already started. See page 397 of this JOURNAL.

*Ogden, Henry, M.D.: Report of Headache Survey, Bulletin of the Louisiana State University School of Medicine, Jan. 1957.

State Activities • • •

The First Aid Squad Movement in New Jersey

JOSEPH PEYSER, M.D.*

Volunteer First Aid Squads are made up of citizens who are dedicated to the practical application of the Golden Rule. In Hillside, squad members include a housewife, a lawyer, factory worker, accountant, contractor, bus driver, teacher, salesman, as well as others in almost every field of endeavor.

The average squad has 5 areas of service. First, at any hour and in any weather the members are prepared to render emergency first aid in illness or accident. A well equipped ambulance and trained personnel respond within a few minutes after being called. Second, transportation calls to and from a hospital, whether emergent or not, are handled with care and courtesy. Third, equipment, such as a hospital bed, wheel chair, crutches, oxygen tent, and so forth, are available and are lent to patients while ill or convalescing. Fourth, the first aid instructors within the squad train policemen, firemen, industrial employees and others. They also continually conduct refresher courses to make squad members more proficient in their work. Fifth, the members have safety drives to point out to the general public the urgent need for safety at home, on the job and on the highway.

There is no charge for any of these services but many people do show their gratitude by making contributions which are used by the squad to replace and increase their equipment.

Our state has always been in the forefront in first aid work. This month the New Jersey First Aid Council is observing its 28th Anniversary. It is this Council which knits closer together the 261 local units, now members of the state organization, encourages the formation of new squads, and serves as a clearing house to promote the First Aid movement in New Jersey. Similar work on a world-wide scale is done by the International Rescue and First Aid Association, organized in 1948, of which the Council and many local squads are members.

In 1956 the 261 Squads of the State Council handled 79,213 calls. Their ambulances travelled 1,472,780 miles. The members devoted 546,801 hours to their work.

I am proud to work with the Hillside Ambulance Squad and I urge other physicians to become closely associated with their own local first aid units.

Oriental Influenza May Move East

The Director of Laboratories, State Department of Health, advises the JOURNAL as follows:

The exact extent of epidemic influenza prevalent in the Far East and nearby areas has not been fully defined but is known to be extensive. Reports are that the disease is mild; but deaths have been recorded.

Spread to New Jersey is a distinct possibility by persons carrying virus entering this country in considerable numbers from the epidemic areas.†

Accurate diagnosis is difficult without laboratory aid. The State Health Department's Division of Laboratories is preparing to offer tests for the virus isolation and for serologic tests to detect presence of the above specific influenza strain.

The virus can be isolated from *throat washings* of patients. Optimally, throat washings should be obtained during the first three days of illness and while the patient is still febrile, although virus may be recovered as long as 7 days after onset. The patient should gargle repeatedly with 10 to 15 ml. of diluent (broth, skimmed milk or distilled water) in a paper cup. Some infective material may be brought

† See page 390, this JOURNAL.

*Township Physician, Hillside, N. J., Trustee, Hillside Ambulance Squad.

from the trachea into the pharynx if the patient will cough. The washings should be transferred to a closed tube for transportation to the laboratory and tested as soon as possible. If a delay of a few hours is necessary, the fluid should be kept chilled at refrigerator temperatures. When longer periods of storage are unavoidable, the washing should be frozen and stored, preferably near 70 degrees centigrade (dry ice). The throat washings should be delivered (do not mail) to: Division of Laboratories, State House, Trenton, N. J.

Serum samples should also be taken; one during the time of illness and a second two to four weeks later.

Rapid identification of this virus in all cases presenting influenza-like symptoms is imperative.

Revised Tuberculosis Report Forms

Prevention and control of tuberculosis in New Jersey are hampered by delay in reporting cases and by inadequacy of information submitted. Of the 1455 known tuberculosis deaths in 1954 and 1955, 479 (33 per cent) were never reported to health departments as cases; an additional 78 deaths (5.4 per cent) were first reported as cases within one month prior to death. In the same two-year period, there were 2962 first admissions to tuberculosis hospitals in the state. Of the first admissions 91 per cent were admitted with moderately advanced or far advanced active lesions.

An enormous amount of correspondence has been necessary to secure omitted essential information. A study of methods to obtain adequate reporting with maximum simplicity and minimum effort to physicians, reporting officers and others involved has resulted in a revision of the case report forms.

New forms for reporting cases of tuberculosis in New Jersey, effective July 1, 1957, *are available from reporting officers of local boards of health.*

Physicians are urged to familiarize themselves with these new forms . . . and to use them.

Cases will be reported as heretofore to the local board of health of the municipality where diagnosis was made. The newly revised confidential mailing form TB 197-MD will be used in accordance with printed instructions thereon. Attention is invited to the need for:

1. Specific residence of the case—county, municipality and street address, which may differ from the mailing address.
2. Satisfactory completion of all items including extent of disease (if pulmonary) and both clinical and bacterial status for all cases.
3. Name and address of physician having medical supervision of case.

The local health board will have to communicate with you to get the missing data if your form is incomplete.

This is one of the situations where our patients get the best break by the cooperation of private medical practitioners and public health officials.

Seton Hall Appointments

The Seton Hall College of Medicine and Dentistry announces the following appointments:

George A. Condouris, Ph.D.
Assistant Professor of Pharmacology

Shel'on B. Gertner, Ph.D.
Assistant Professor of Pharmacology

Pasquale James Costa, Ph.D., M.D.
Associate Professor of Pharmacology

Zigmund C. Kaminski, Ph.D
Instructor, Department of Bacteriology

Howard William Marraro, M.D.
Instructor, Department of Medicine

County Society Reports • • •

Cumberland

The June meeting of the *Cumberland County Medical Society* was called to order by its president, Dr. Paul K. Ayars on Tuesday, June 11, 1957 at 2:30 p.m. The Society was the guest of the Owens-Illinois Glass Company at its unique Onized Cabin on Palatine Lake. There were 69 acceptances out of a possible 88 members present. Honored guests present were: Dr. Albert B. Kump, President of The Medical Society of New Jersey, who introduced two members of the Executive Office staff of The Medical Society of New Jersey: Mrs. Edith L. Madden, Administrative Secretary and Convention Manager and Mrs. Margaret B. Stockton, Supervisor of Membership, Directory, and Physicians Placement. Dr. Kump also took the opportunity to express his personal appreciation to the members of the Society for the excellent support and reception given him at the annual meeting in Atlantic City at which time he was inaugurated.

Dr. Harry D. Sugar of Vineland was unanimously elected to active membership in the Society.

The Maternal Welfare Committee, headed by Dr. Mary Bacon, who is also County Field Physician for the Bureau of Maternal and Child Health of the State Department of Health, was increased to 4 members by the addition of Dr. John J. Biancho. The committee now consists of Dr. Mary Bacon and Dr. Jesse W. Carll of Bridgeton, Dr. Calvin Hahn and Dr. John J. Bianco of Vineland.

The meeting was adjourned at 3:30 p.m. and all retired to the spacious picnic-grounds of the Onized Cabin, where the blue skies and sunshine trickling through the foliage of the summer trees provided a natural canopy. The aroma of food pierced the wooded surroundings with such fragrance that it solicited the attention of everyone. A most delicious and appetizing dinner was served picnic-fashion and was heartily enjoyed by all.

The Cumberland County Medical Society expresses its appreciation to the Owens-Illinois Glass Company and its committee of Mr. Herbert Hill, Mrs. Cel Ghedine, Miss Lorraine Towers, Mr. Harry Haines, Mr. William Clark and Mr. Salvi Blandino for this excellent reception.

LEONARD G. SCOTT, M.D.

Reporter

Hudson

The annual meeting of *Hudson County Medical Society*, terminating the official year of 1956-1957, was held at Jersey City Medical Center, on May 7. Dr. John E. Annitto presided. Dr. Vasilius Dross of Jersey City was elected to active membership.

The following were elected to serve during the official year of 1957-1958:

Dr. Harold Gorenberg—President
Dr. John J. Bedrick—President-Elect
Dr. Charles E. Rosen—Vice-President
Dr. Charles A. Landshof—Secretary
Dr. Nathan J. Plavin—Treasurer
Dr. Matthew E. Boylan—Reporter

Guest speaker was Dr. Walter L. Mersheimer (son of Dr. Christian H. Mersheimer of Jersey City), Associate Professor of Surgery at New York Medical College. Subject of Dr. Mersheimer's presentation was Intestinal Obstruction. Dr. Waters and Dr. Perlberg, Sr., participated in a discussion from the floor.

MATTHEW E. BOYLAN, M.D.

Reporter

Middlesex

The annual dinner meeting of the *Middlesex County Society* was held at Oak Hills Manor, Metuchen, on June 19. The members started to gather at 7:00 p.m., sitting down to dinner after a thirty minutes hospitality session.

The meeting was called to order by Dr. Becker, the president at 7:45 p.m. The following elections to membership took place:

To regular membership from two-years associate membership: Dr. Margaret Delaney, East Brunswick and Dr. John P. Cryan, East Brunswick.

Reinstated to active membership following return from active service with U. S. Armed Forces: Dr. T. Lloyd Kolbay, Metuchen.

To honorary membership: Dr. John J. Reason, Carteret.

To two years associate membership: Dr. Henry Keen Shoemaker, New Brunswick.

Dr. Calvin, Chairman of the Constitution and By-Laws Committee, stated his work would continue over the summer and be ready to be submitted in the fall. Dr. G. J. Kohut gave the Treasurer's report and received a rising vote of thanks from the floor for his years of competent and untiring service in that capacity, which he is resigning to become vice-president.

The new slate of officers was then nominated and unanimously approved as follows:

President—Gerard R. Gessner, M.D., New Brunswick

Vice-President—George J. Kohut, M.D., Perth Amboy

Secretary—Robert J. Zullo, M.D., New Brunswick

Treasurer—Reuben Levinson, M.D., Perth Amboy
Reporter—Rudolph G. Matflerd, M.D., New Brunswick

Dr. Becker, the retiring president, thanked the members at large for their fine cooperation during the year although he expressed regret at the lamentable attendance during this time. He then introduced Dr. Gessner, incoming president and his officers. Dr. Gessner made several interesting introductory remarks.

After a tasty dinner, the group was entertained by Bill McDonald, of Boston, a comedian. The meeting was adjourned at 9:40 p.m.

MORTON M. KLEIN, M.D.
Reporter

Obituaries • • •

DR. ROBERT H. HILL

A native of Ohio, Dr. Robert H. Hill was graduated in 1926 from the College of Physicians and Surgeons of Columbia University. His first contact with New Jersey was in 1926 when he was appointed an intern at the Newark City Hospital. He remained in Newark thereafter from 1926 until his death on June 25, 1957. Dr. Hill was 63 years old at the time of his death. After a short period of general practice he began to devote himself more and more to surgery becoming an FACS, and then a diplomate of the American Board of Surgery. He was active in the affairs of the Essex County Medical Society and was on the surgical staffs of the Presbyterian, Babies' Hospital and Eye and Ear Infirmary in Newark.

DR. DANIEL L. ROTHSCHILD

On June 10, 1957 Dr. Daniel L. Rothschild died at the age of 50. A native of Newark, he attended —and played varsity football at—Cornell University. In 1930 he received his M.D. from the medical school of Cornell University. After his internship, he did general practice for a few years but found himself increasingly interested in obstetrics and gynecology. During World War II, he served as a lieutenant commander in the U. S. Navy. He was on the staff of both Beth Israel and Irvington General Hospitals.

DR. MARTHA TYNDALL

On June 22, Dr. Martha W. Tyndall died at her home at the age of 63. Dr. Tyndall came of a medical family. She practiced in Westfield, sharing the office with her sister, Alice. Their brother Hugh is attending surgeon at St. Mary's Hospital, Hoboken. Dr. Martha Tyndall was a general practitioner, affiliated with the hospitals in both Plainfield and Rahway. She was a member of the Union County Medical Society.

DR. PETER D. WESTERHOFF

Dr. Peter D. Westerhoff, one of New Jersey's most colorful medical figures, died on the first day of summer, 1957. Dr. Westerhoff was a football star, a nose and throat diplomate and the mayor of Midland Park. He was born in Paterson in 1896. In 1924 he was graduated from the Long Island College of Medicine. He was a football hero in his high school and college days. He interned at the St. Joseph Hospital in Paterson. He served in both world wars—as a lieutenant in the then infant tank corps in 1918 and as a major in the medical corps in 1942. A certified otolaryngologist, he was on the staff of the St. Joseph Hospital in Paterson. He was mayor of Midland Park in 1941-42, leaving that office to accept a commission in the Army Medical Corps.

Announcements • • •

Approved Urology Residency

A full 3-year approval of its urology residency is announced by VA Hospital, East Orange. Positions available now. Salary ranges from $2800 to $4000. For details write to Director of Professional Services, Veterans Administration Hospital, East Orange, N. J.

Industrial Dermatology

An intensive five-day course in "occupational skin problems" is available in Cincinnati to a limited number of registrants. This is a joint project of the USPHS and the University of Cincinnati. For details, write to Institute of Industrial Health, Eden and Bethesda Avenues, Cincinnati 19, Ohio. The course begins October 28.

Endocrinology and Metabolism Seminar

A 5-day full-time course in metabolism and endocrinology is announced for October 21 through 25 at the Medical College of Georgia in Augusta. Tuition is $100. AAGP credit is 35 hours. For further details write to: Chairman of Endocrinology, Medical College, Augusta, Georgia.

Short Course in Compensation Medicine

Announcement is made of a 5-day course (mornings and afternoons) in compensation medicine, October 21 through 25, at New York University. The program covers the medico-legal aspects of heart disease, rehabilitation, geriatrics, brain injury, backache, radiation, back injury, and even tranquilizers. For details write to the Associate Dean, Postgraduate Medical School, 550 First Avenue, New York 16, N. Y.

Radiation Course

A one-week course in radiation for industrial physicians and lawyers is offered by the University of Cincinnati during the week of September 9. This course, the first of its kind, will enable each profession to understand the problems, professional responsibilities and limitations of the other when dealing with medical or legal questions posed by the use of ionizing radiation.

Enrollment is limited. Tuition is $100 per person. For further information and application write: Secretary, Institute of Industrial Health, Kettering Laboratory, College of Medicine, University of Cincinnati, Cincinnati 19, Ohio.

Have You Ever Been to Turkey?

If you have never seen the Bosphorus, if to you Constantinople is only a hard word to spell, here is a chance to see Turkey for yourself. The World Medical Association is meeting in Istanbul September 29 through October 5. If you are a physician, and if you live in this world, you are eligible for the World Medical Association. The scientific program provides something for every professional interest. For details write to World Medical Association, 10 Columbus Circle, New York 19, N. Y.

Hawaii in November . . . Why Not?

The Pan-Pacific Surgical Association meets in Hawaii November 14 through November 22. The program will be focused on usable surgery both for the surgeon and the general practitioner. For details write to Director-General, Pan-Pacific Surgical Association, 230 Young Building, Honolulu 13, Hawaii.

Cancer Seminar

The Fifth Annual Cancer Seminar will be held at the Hotel President, Atlantic City on Saturday afternoon and Sunday, November 16 and 17. Arrangements for the seminar are being made by the Professional Information Committee of the New Jersey Division of the American Cancer Society, of which Dr. Joseph I. Echikson, of 31 Lincoln Park, Newark, is chairman.

Among the topics to be discussed in the program are those pertaining to "Cancer in Children," "Causative Factors of Cancer of the Lung," "Diagnosis and Treatment of Uterine Cancer," "Moles and Melanomas," "Carcinoma in-situ" and the "Role of Research and Cancer Therapy."

More details may be obtained from Dr. Echikson.

Medical Education Loan Fund

New Jersey residents are eligible to participate in the Medical Student Loan Fund created by the New Jersey Chapter of the American College of Surgeons. For details, write to Dr. Harold MacArt at 120 Prospect Street, South Orange, N. J.

Trudeau Society

The Eastern Section of the American Trudeau Society meets in Atlantic City on October 18 and 19. All physicians interested in chest medicine are welcome. Write to Dr. Joseph A. Smith, Glen Gardner, New Jersey, for details.

English Study for Foreign Doctors

Foreign-born physicians will be interested in the availability of a course in practical English which will be given at the Washington Square Center of New York University. The course starts on September 26 and continues every Thursday thereafter through January 23, 1958. The lectures begin at 6:15 p.m. and terminate at 8 p.m. Further details may be obtained from the Director of the English Language Program for International Students, Division of General Education, New York University, New York 3, N. Y.

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Liver, Biliary Tract and Pancreas. Frank H. Netter, M.D., Part III of Volume 3, "Digestive System," The Ciba Collection of Medical Illustrations. Pp. 165. Summit, N. J. Ciba, 1957 ($10.50)

There is a great deal of current interest in the liver and the literature on it is becoming very extensive. With such an abundance of new material, it is to be expected that the form in which it appears varies from essayist to essayist. None have taken the form of paintings which fundamentally comprise this book. This is the third of a three-part series devoted to the digestive tract. Parts I and II on the upper and lower gastro-intestinal tract are in the process of completion.

The usual phases of normal anatomy both gross and microscopic, development, topography, surgical approaches and variations of the liver, biliary system and pancreas are pictorially described. The pathophysiology, liver function tests and their relation to paper electrophoresis, metabolism of the pancreas, functions of the gall bladder, are facets of this novel book which are depicted in two-dimensional paintings. Cholecystography, cholangiography, portal venography, liver biopsy and other aids in diseases of the pancreas and liver, are all briefly described in picture form. From the clinical aspect one can at a glance refresh his memory of such diseases as Kwashiorkor or portal hypertension; bile duct fistulae or ampallary tumors; congenital cystic disease of the pancreas or pancreatic tumors. Neither the artist nor the collaborators have tried to settle any of the controversies that exist in our newer knowledge of the functions and diseases of the organs discussed. They do, however, present them in the light of current research.

The contributors have written a descriptive text which accompanies each illustration. The subject index is compiled in such a way that any topic

may be found with ease. The illustrations of anatomy, pathology, physiology and the medical situations which surround them make this book truly a work of art. It is a useful and welcome addition to the library of the gastro-intestinal internist, the surgeon and the general practitioner.

SYDNEY ROSENTHAL, M.D.

Pulmonary Carcinoma: Pathogenesis, Diagnosis and Treatment. Edited by E. Mayer, M.D. and H. C. Maier, M.D. Pp. 540. Philadelphia, Lippincott, through arrangement with the New York University Press, 1956. ($15.00)

This well written and well edited book covers all aspects of pulmonary carcinoma. It succinctly summarizes history, pathogenesis, diagnosis and therapy. Frills have been omitted. The contributors, all authorities in their respective fields, are familiar with the overall problem of lung cancer.

Pathologists and clinicians alike will be aided by excellent chapters on the pathological aspects of lung disease, pulmonary function and physiology and the survey of the therapeutic armamentarium in the treatment of lung cancer.

The book is practical and factual. The well illustrated chapter on exfoliative cytology could well be a model for brevity, conciseness, and factual organization for future texts on this subject. The chapter on radiation therapy gives an excellent discussion and summary of available treatment technics.

The book closes with an atlas of brief case presentations, each concluding with an outline of the lesson taught by the case. This serves to illustrate many features of the text.

This book is a compilation of the best in current knowledge of cancer of the lung, which is of a practical nature. No physician, whether a general practitioner or specialist can read this book without benefiting his pulmonary cancer patient. It is a timely book on an increasingly prevalent disease.

WILLIAM O. WUESTER, M.D.

The Doctor as a Witness. John Evarts Tracy. Saunders, 1957. Philadelphia. Pp. 221. ($4.25)

Most civil trials require medical testimony, and most physicians have occasion to testify during their professional careers. A doctor may hurt his patient if he refuses to go to court. His snubbing the court room may, indeed, lead to a miscarriage of justice. Yet the doctor is often afraid of the witness box. Many books have been written on the physician as a witness. Most of these books are packed with pious platitudes to the effect that all the doctor has to do is to armor himself with the truth and he becomes unassailable. This is a serious oversimplification. What the doctor needs is a sophisticated road map through the court room. And this book provides it.

Professor Tracy gives an adequate, and interesting, grounding in substantive law. His advice is helpful. His examples illuminate. He covers every aspect of medical testimony from pretrial preparation to court room etiquette. He has a few crotchets—which is every author's privilege. One is a rigid hostility to the contingency fee even if it means depriving a poor man of medical testimony. He also expects doctors to testify against their brethren in malpractice cases and is blind to the psychological identification which makes such testimony unacceptable to most MDs. And he conjures up situations where he expects the physician to testify against his own patient. But apart from these oddities, the book is solid and helpful. Since I, too, have written a book on one facet of forensic medicine, I consider it very generous of me to praise Professor Tracy's text. But its merit cannot be denied. It is a wise and witty *vade mecum*—and interesting reading too.

HENRY A. DAVIDSON, M.D.

The Compleat Pediatrician. Wilburt C. Davison, M.D. and Jeana D. Levinthal, M.D. 7th ed. Duke University Press, Durham, N. C. 1957. ($4.25)

The old reliable *Compleat Pediatrician* has been rewritten. This new edition includes new material on antibiotics, electrolytes, steroids, and anticonvulsants. It is a practical guide that will serve as a *vade mecum* for interns, pediatricians, medical students and family doctors. It is also an ideal book for the specialist in the non-pediatric field to have on his shelf. Primary arrangement is by symptom. The physician looks up the presenting complaint—nasal bleeding, for instance—and finds a list of causes with a key number affixed to each. The key number takes the reader to the definitive paragraph. The arrangement permits swift reference in time of need. The advice is practical. The text is thinned down to the point where all purely theoretical material has been eliminated. About 50,000 doctors have bought previous editions of this book. And 50,000 doctors aren't wrong.

RALPH N. SHAPIRO, M.D.

Clinical Laboratory Methods. By W. E. Bray, M.D. St. Louis, 1957, Mosby. Pp. 731. Ed. 5. ($9.75)

Since 1946 Bray has been a bible for pathologists, interns, GPs, and technicians. This 1957 edition maintains the highly satisfactory arrangement which has made Bray so consistently useful. Tests are crisply given, directions are clear, illustrations are used when necessary, and clinical significance is explained. This 5th edition includes material on Salk vaccine. The book has been reduced to a 5 by 8 size so that it can be conveniently carried and consulted. Material on radio-active

iodine is included as well as new material on transaminase and doubly refractile lipoids. The book covers the examination of blood, gastric juice, urine, feces, sputum, spinal fluid, body smears, bacteria, milk, fungi, and water. There is a chapter on metabolism testing and on gages of thyroid function, one on allergy testing, one on poisons and one on surgical pathology. Also included is useful material on specimen collection, indicators, and even on the removal of laboratory stains from clothes. Altogether a lot of book for less than ten dollars!

ULYSSES M. FRANK, M.D.

Physiologic Principles of Surgery. By L. M. Zimmerman, M.D. and R. Levine, M.D. Pp. 988, Philadelphia, Saunders, 1957. ($15.00)

Physiologic Principles of Surgery is a welcome addition to the surgeon's library. While it is written by numerous collaborators, it is not repetitious or verbose. The chapters are generalized where indicated, but are usually limited to each system. The bibliographies are excellent.

This book describes the most recent research in many fields. A good example is in the chapter on transplantation of tissues. Also included is a brief description and evaluation of a number of operative procedures and their indications.

The chapters on the surgery of the new born and congenital heart disease are worthy of further mention. Each type of congenital heart disease is discussed in an orderly way, including the embryopathy, pathologic physiology, clinical characteristics, laboratory aids, and treatment. The discussions of cardiac catheterization, angiocardiography, roentgenography, and electrocardiography are concise and without too much detail. The authors have ably condensed into one volume many physiologic concepts that may be easily and beneficially read not by surgeons alone, but by all students of medicine.

JACK GRUNDFEST, M.D.

Third National Cancer Conference, 1956. Pp. 961. Philadelphia, Lippincott, 1957. ($9.00)

Embodied in one volume is the most recent, complete, authoritative and thought provoking work dealing with the cancer problem in all its phases. Here will be found a careful and well organized compilation of contributions by leading workers from all over the world in the field of cancer. The areas covered include: Epidemiology as a tool; radiation neoplasia; chemical effects of growing tumors on the host with special reference to iron; the possible virus etiology of cancer; factors influencing curability and measurement of morbidity.

Also included are symposia and panels dealing with diagnosis and treatment of neoplasms of the breast, prostate, lymphomas and leukemias, lung, head and neck, genital tract, gastro-intestinal tract and the use of chemotherapy today.

The entire conference is then summarized with an "end result" symposium.

This volume is indispensable for all physicians who deal with any phase of cancer, research, diagnosis, or treatment.

The contributions to this conference will serve as a guide and reference as to approaches toward the one common problem: control of cancer.

ROY T. FORSBERG, M.D.

Meprobamate and Other Agents in Mental Disturbances. Edited by Otto v. St. Whitelock. Pp. 222. Paper. New York Academy of Science. ($4.00)

In October 1956, the New York Academy of Sciences held a conference on behavior influencing drugs. This brochure is one of the *Annals* of that Academy, detailing the 24 papers read there. Subjects covered include the pharmacology of meprobamate, its clinical use in the treatment of psychoneuroses, the role of the drugs—especially meprobamate in the psychoses, the utilization of the pharmaceuticals in muscle spasm, and a charming introductory essay on "the history of tension," by Aldous Huxley. None of the authors reported that the drug was useless or toxic. There is no index.

HERBERT BOEHM, M.D.

Vegetable Oils in Nutrition. By Dorothy M. Rathmann, Ph.D. Corn Products Refining Company, New York 4. (1957). Gratis

This monograph explains the nutritional merits of vegetable oils, and the effects of unsaturated fats on blood cholesterol levels. The discussion centers around the effects of diet on tissue lipid compositions, explaining low, normal and high fat diets.

The monograph is distributed by the Corn Products Refining Company and it deals primarily with their brand, Mazola Oil.

An undue elevation in serum lipids and lipo proteins may be influenced by dietary fat intake. This, however, is not the entire basis in promoting atherogenesis. Many of the factors inherent in the arteries, arterioles, and circulation cannot be overlooked. Since Mazola corn oil contains linoleic acid and sitosterols, one can assume that such an unsaturated vegetable oil results in lowering the serum cholesterol level more readily than do those containing more highly saturated fats.

We are still waiting for more convincing evidence of a difference in dietary fats as they influence circulating lipids. This monograph is a good digest of the subject of vegetable oils in nutrition.

S. WILLIAM KALB, M.D.

TUBERCULOSIS *Abstracts*

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Vol. XXX August, 1957 No. 8

A Challenge

By S. Marx White, M.D., Editorial, Journal-Lancet, January, 1957.

● Tuberculosis is still a scourge despite modern drugs and excisional therapy.

Sanatorium care remains the best hope for the patient—and his family. Figures from Minneapolis and Hennepin County are cited to illustrate the extent of the problem.

In 1947, the use of streptomycin in the treatment of tuberculosis gave a sudden lift to hopes for the eventual conquest of the disease. Since that time combinations with PAS and isoniazid have provided added effectiveness. Other drugs are being intensively studied in hospitals and sanatoria. This avenue of approach seems certain to improve.

When the surgical removal of the cavitated discharging, and therefore infective, portion of the diseased lung became possible, a wave of optimism struck not only the public but the medical profession as well. A feeling arose that we would find an early solution to the problem of eliminating tuberculosis. Such optimism is not justified. The attack is still from the wrong angle.

True, the known case, if properly treated, is now restored to the community as a contributor to the economy and not a distributor of infection. However, the process is still slow and painstaking and full of pitfalls for the unwary. Management if it is to be successful must be unwavering and uninterrupted and requires the utmost skill and training. The cooperation of the patient and the family is necessary. Treatment must be continued indefinitely after recovery or apparent arrest.

The family physician must be alert. He will be importuned to assume the care in the home of the active case. According to Dr. James E. Perkins, Managing Director of the National Tuberculosis Association, the cost of the average case of tuberculosis is about $15,000 including medical care, compensation, pensions, relief payments, and loss of wages. Few can bear such a burden without assistance. Nearly everyone wants to be cared for at home.

Few people are sufficiently informed to desire treatment in a sanatorium. Unless the physician is alert to the probable course of the disease and firm in his advocacy of sanatorium care, he may yield to entreaties and attempt home treatment with drugs. Soon the patient becomes aware of the expense involved. In time, he may assume that he has sufficiently recovered and abandon the treatment. This has occurred repeatedly. The physician is left helpless, and the patient is often hopeless. Many instances of the situation can be cited by anyone with experience in the field.

In the sanatorium, the entire cost of long-term care is supplied except for the very small percentage of patients who can well afford such expense. In fact, the patient who is charged a token part pays less for sanatorium treatment than for home care. Infinitely more important are skill and specialized medical care by a staff alert by experience to the many pitfalls awaiting the unwary.

In the sanatorium, a rehabilitation program under skilled management is started immediately with education, occupational therapy, medical social service, and vocational guidance and placement, which is the *sine qua non* of a successful program of restoration. Such a program can be furnished only by an institution. Indefinite follow-up is needed to forestall the consequences of relapse.

However, the attack has just begun in spite of the mounting success in removing the patient with a known case of tuberculosis from his community as a source of infection and restoring him as a productive citizen to the community. While the

death rate has already fallen, the incidence still remains little below that of ten years ago. Community-wide surveys, incomplete as they are, reveal shocking numbers of individuals in the infective stage who are unrestricted in the community and seeding the germs of the disease in ways which often we cannot as yet trace.

The 149 new active cases found in Minneapolis and Hennepin County in 1954 illustrate this point. Of these cases, 36 per cent were reported from physicians' offices and public clinics, and 22 per cent were hospital inpatients. Mobile-unit surveys and physical examinations with roentgenograms of apparently healthy people located 23 per cent. Follow-up of contacts of active cases accounted for 7 per cent; 2 per cent were found in death reports and were not previously reported. An additional 10 per cent of the cases had been diagnosed elsewhere.

The average attack rate in 1950 to 1954 by age and sex shows that men over 45 years of age comprise the group most likely to develop tuberculosis. Many of them are still supporting a family. The "dangerous age" for women is from 25 to 44, and for every woman who breaks down in this age period, there are almost twice as many men. In the occupational groups, new active case rates in 1954 were highest among the unemployed and next among food handlers and maids.

Routine roentgenographic surveys of all hospital admissions bring to light a significant number of cases. Sanatorium staffs also report a sequence that has not received sufficient attention from the general medical profession. Many cases appearing at first to be atypical, or so-called "virus" pneumonia, recover from the acute attack only to break down much later and prove the original infection to be of tuberculosis origin instead of "virus." The development is usually so insidious and symptomless that only frequent and systematic follow-up can detect this sequence before it becomes a cavitated source of illness and infection.

Conditions in sanatoria throughout the nation quite generally follow a pattern illustrated by the stage of disease on admission recorded in Minnesota's Glen Lake Sanatorium. Approximately 10 per cent only are incipient and usually nonspreaders. Fifty per cent are moderately advanced, and 40 per cent are definitely far advanced. Thus, nearly 90 per cent of those admitted are spreaders of the disease. The local conditions cited illustrate the fact that innumerable sources of infection are present in a community which prides itself on accomplishment in this field.

Tuberculosis exists throughout the known world and has existed since disease in man became known. The causative organism has been known only for a moment in human history. Our success in its suppression has just begun. There is an enormous amount of tuberculosis in countries in which health measures are still retarded.

When we turn to our own country, we learn through the National Tuberculosis Association that "if by magic we could eliminate today all the known tuberculosis cases, we would still have about 50,000,000 people in this country harboring live, virulent tubercle bacilli in their bodies." This seems incredible until we remember that in the vast majority, the disorder is inactive. The impressive fact is the wide-spread silent character of the infection.

Here we rest our case. We conclude:

1. Efforts to find the active spreader of infection need to be intensified. While greater search must be made among the ethnic, occupational, and age groups most heavily infected, all possible sources must be explored.
2. All known cases must be removed from situations in which they can infect others. Isolation provided by the sanatorium is the only assurance against such infection.
3. Treatment now available must be applied under competent management without prospect of interruption and with complete rehabilitation as an added objective. Such treatment means sanatorium care.
4. Research must be intensified. There must be no letdown in the provisions for sanatorium care. Adequate facilities must be provided for communities not so equipped.

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1. Pitt, M. B.: Leukorrhea. Causes and Management, J. M. A. Alabama *25*:182 (Feb.) 1956.
2. Parker, R. T.; Jones, C. P., and Thomas, W. L.: Pruritus Vulvae, North Carolina M. J. *16*:570 (Dec.) 1955.

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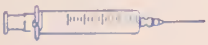
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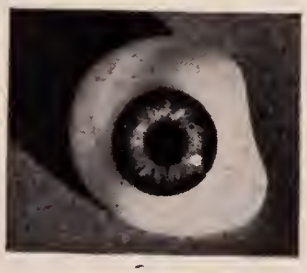
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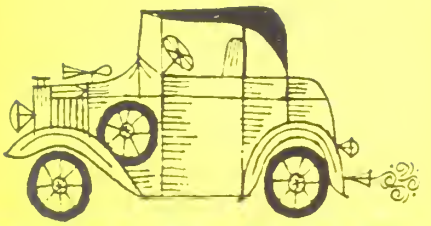
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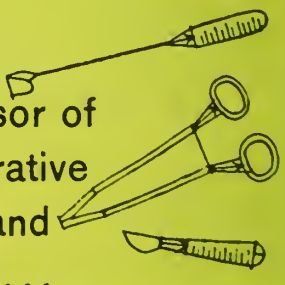
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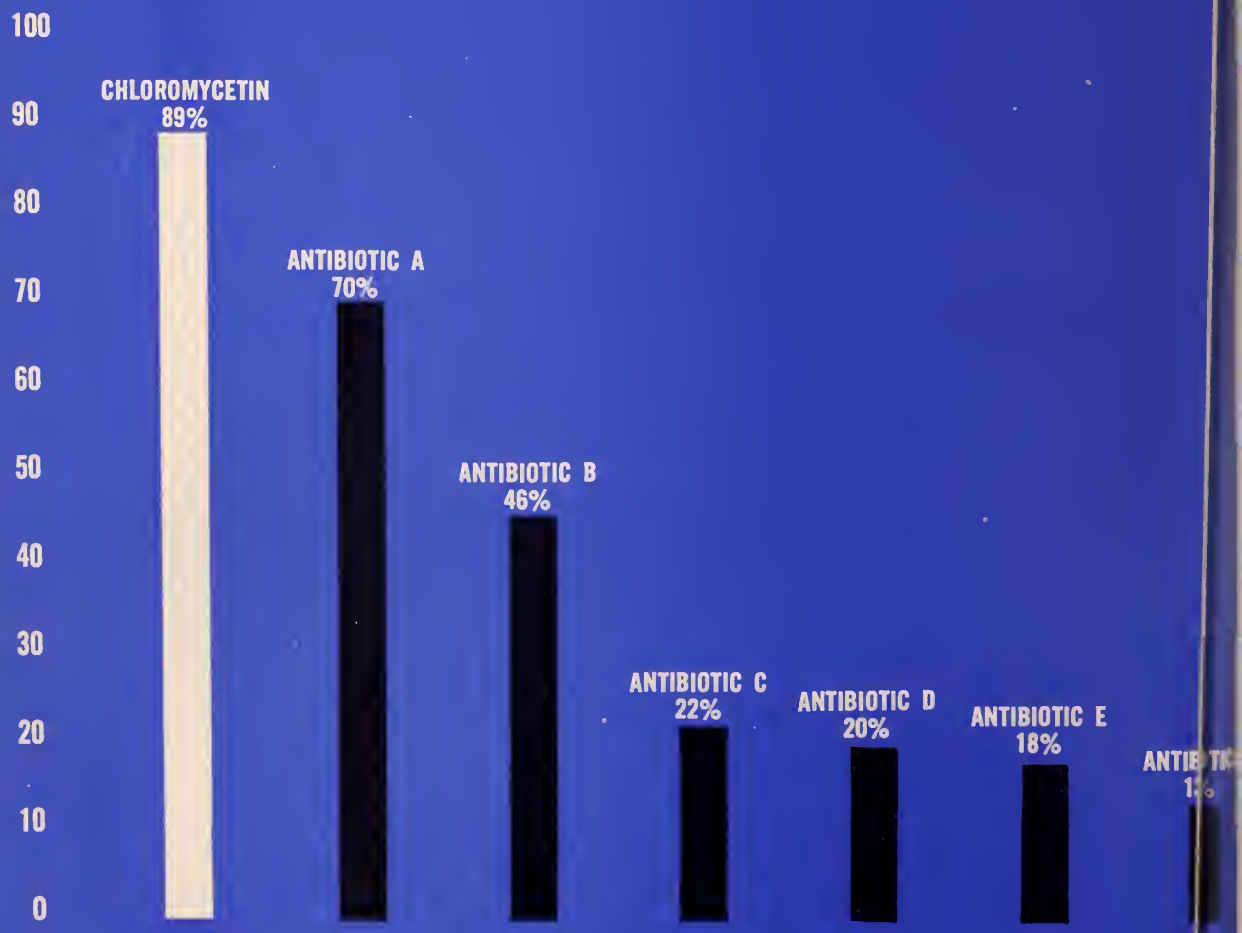
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The long-established Belle Mead Sanatorium, located near Princeton, New Jersey, is now called "The Carrier Clinic". The Carrier Clinic will, of course, carry on the traditional purpose of Belle Mead to apply the most advanced psychiatric techniques to the care of the emotionally disturbed. And too, the clinic now has added accommodations for the arteriosclerotic and the senile

Resting on 350 acres of beautifully landscaped grounds are modern hospital facilities providing intensive psychotherapy as well as electro-shock, deep insulin and chemo-therapies. Also through the use of its occupational and recreational equipment the clinic is able to offer its patients arts and crafts, music and athletics.

The Carrier Clinic is a contracting hospital of the New Jersey Blue Cross Plan.

THE CARRIER CLINIC

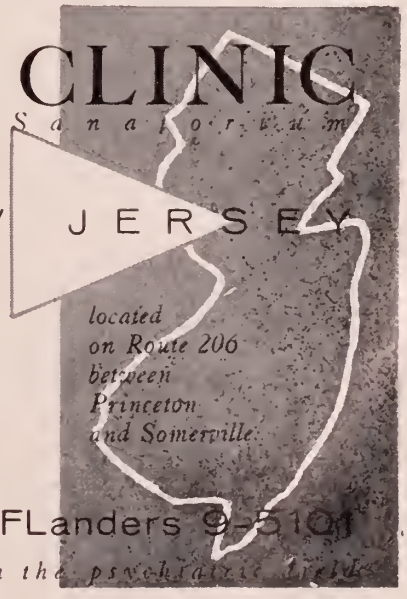
formerly Belle Mead Sanatorium

BELLE MEAD, NEW JERSEY

MEDICAL DIRECTOR
RUSSELL N CARRIER, M.D., F.A.P.A
DIPLOMATE IN PSYCHIATRY

ASSOCIATE PSYCHIATRISTS
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DIPLOMATE IN PSYCHIATRY
PERCY H. WOOD, M.D
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HOSPITAL ADMINISTRATOR
MERCEDES PEIFER, R.N



telephone FLanders 9-5101

for the diagnosis, treatment and research in the psychiatric field

V stands for—greater antibio

blood levels • faster broad-spectr

ACHRO

is a new and superior form

widely prescribed broad-spectru

in the treatment of more th

ACHROMYCIN V Capsules a

practically twice the absorpti

oral broad-spectrum

ACHROMYCIN V is now available in—**CAPSULES.** (Pink) 250 mg., 100 mg. (tetracycline HCl equival

phosphate-buffered.) **SYRUP.** Each teaspoonful (5 cc.) of orange-flavored syrup contains 125 mg. of tetracy

HCl activity, phosphate-buffered. **LIQUID PEDIATRIC DROPS.** Each cc. (20 drops) contains 100 m

tetracycline HCl activity, phosphate-buffered. (Approx. 5 mg. per drop). Orange Flavor. Plastic dropper-type bottle of 1

sorption · earlier therapeutic

tion

MYCIN* V

Tetracycline Buffered with Phosphate

HROMYCIN* Tetracycline—the

tibiotic, noted for its effectiveness

0 different infections. New

pid-acting, offer an average of

ı half the time—unsurpassed

erapy.

ROMYCIN V dosage: 6-7 mg. per lb. of body weight per day for children and adults.

MEMBER THE V WHEN SPECIFYING ACHROMYCIN V

S. Pat. Off.

RLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK Lederle

New

NEO-SYNEPHRINE® COMPOUND

Cold Tablets

offer "Syndromatic" Control in the COMMON COLD, Allergic Rhinitis

---

Patients breathe, sleep, work and play better with new "syndromatic" action.

Neo-Synephrine Compound Cold Tablets... for... Full "Syndromatic" Relief.

Neo-Synephrine (brand of phenylephrine) and
Thenfadil (brand of thenyldiamine), trademarks reg. U.S. Pat. Off.

Neo-Synephrine Compound *Cold Tablets*

protect patients through the full range of symptoms

Each tablet contains:

NEO-SYNEPHRINE HCl, 5 mg.

Mild, long acting decongestive

controls **NASAL STUFFINESS, RHINORRHEA**

Acetaminophen, 150 mg.

Effective analgesic and antipyretic

relieves **HEADACHE AND ASSOCIATED ACHES AND PAINS**

Thenfadil® HCl, 7.5 mg.

Dependable, well tolerated antihistaminic

neutralizes **ALLERGIC SENSITIZATION**

Caffeine, 15 mg.

counteracts **MENTAL AND PHYSICAL LASSITUDE**

Dose: **Adults**—2 tablets three times daily.
Children 6 to 12 years—1 tablet three times daily.

Bottles of 100 tablets

Winthrop LABORATORIES
NEW YORK 18, N. Y.

Combined Estrogen-Androgen Therapy Proved 96% Effective in Preventing Postpartum Breast Engorgement[1]

Dual Steroid Approach also Successful in Osteoporosis

Of more than 4 million babies born in the United States this year, approximately 75 per cent will not be breast fed.[2] Combined estrogen-androgen therapy will effectively suppress lactation and prevent postpartum breast engorgement in these mothers.

Osteoporosis also ranks high on the list of present day medical problems because of the increasing older population.

In either condition, combined estrogen-androgen therapy produces a complementary metabolic response with little or no side effects.

In postpartum breast engorgement the rationale of therapy is explained as follows: During pregnancy, the high estrogen titer exerts an inhibitory effect on the anterior pituitary, thereby preventing the release of the lactogenic hormone, prolactin. Postpartum, the estrogen level drops off suddenly, and allows the release of previously inhibited prolactin which is now free to initiate the flow of milk. Sex hormones re-establish pituitary inhibition, thus arresting the lactating process.

In Fiskio's study,[1] "Premarin" with Methyltestosterone effectively relieved postpartum breast engorgement and suppressed lactation in 96.2 per cent of his group of 267 patients. Notably absent were breast abscesses, nausea, vomiting, excessive lochia, withdrawal bleeding or virilization. Menses were re-established after the normal six week period. The lack of mental depression during the puerperium was especially gratifying.

Osteoporosis results from impairment of osteoblastic activity, and gonadal hormone decline is possibly the most prevalent cause. Estrogen stimulates osteoblastic activity and increases calcium and phosphorus retention, while androgen exerts an anabolic or protein-forming action. Prognosis for bone recalcification is good, providing therapy is continued for extended periods. The possibility of side effects is minimized because the two hormones exert an opposing action on sex-linked tissue.

Estrogen and androgen as combined in "Premarin"® with Methyltestosterone provide a treatment of choice in osteoporosis.

Recommended Dosage: (Directions refer to *yellow* tablets.)

Postpartum breast engorgement — Short duration therapy — (one week) — 3 tablets every four hours for five doses — then 2 tablets daily for rest of week. "Step-down" therapy — (10 to 15 days) — 1st day — 4 tablets; 2nd day — 3 tablets; 3rd day — 2 tablets; thereafter, 1 tablet daily for 10 to 15 days. *It is important to start therapy as soon as possible after delivery.*

Osteoporosis: 2 tablets daily, for the first three weeks. Then 1 tablet daily thereafter. In the female, it is suggested that combined therapy be given in 21 day courses with a rest period of about one week between courses, and be continued for 6 to 12 months; following this period, the patient may be maintained with cyclic therapy employing "Premarin" Tablets alone.

Supplied in two potencies: *Yellow tablets* — each contains 1.25 mg. conjugated estrogens, equine ("Premarin") and 10 mg. methyltestosterone. *Red tablets* — each contains 0.625 mg. and 5 mg. respectively. Bottles of 100 and 1,000.

Bibliography: Available on request.

AYERST LABORATORIES
New York, N. Y. • Montreal, Canada

5740



PREVENT P.P.B.E.

Postpartum breast engorgement was satisfactorily prevented in 96 per cent of a series of 267 patients who received "Premarin" with Methyltestosterone promptly after delivery. No serious side effects were noted, and the absence of mental depression in the puerperium was notable. (Fiskio, P.W.: GP 11:70 (May) 1955.)

"PREMARIN"® WITH METHYLTESTOSTERONE
for combined estrogen-androgen therapy

Ayerst®

Ayerst Laboratories • New York, N. Y. • Montreal, Canada

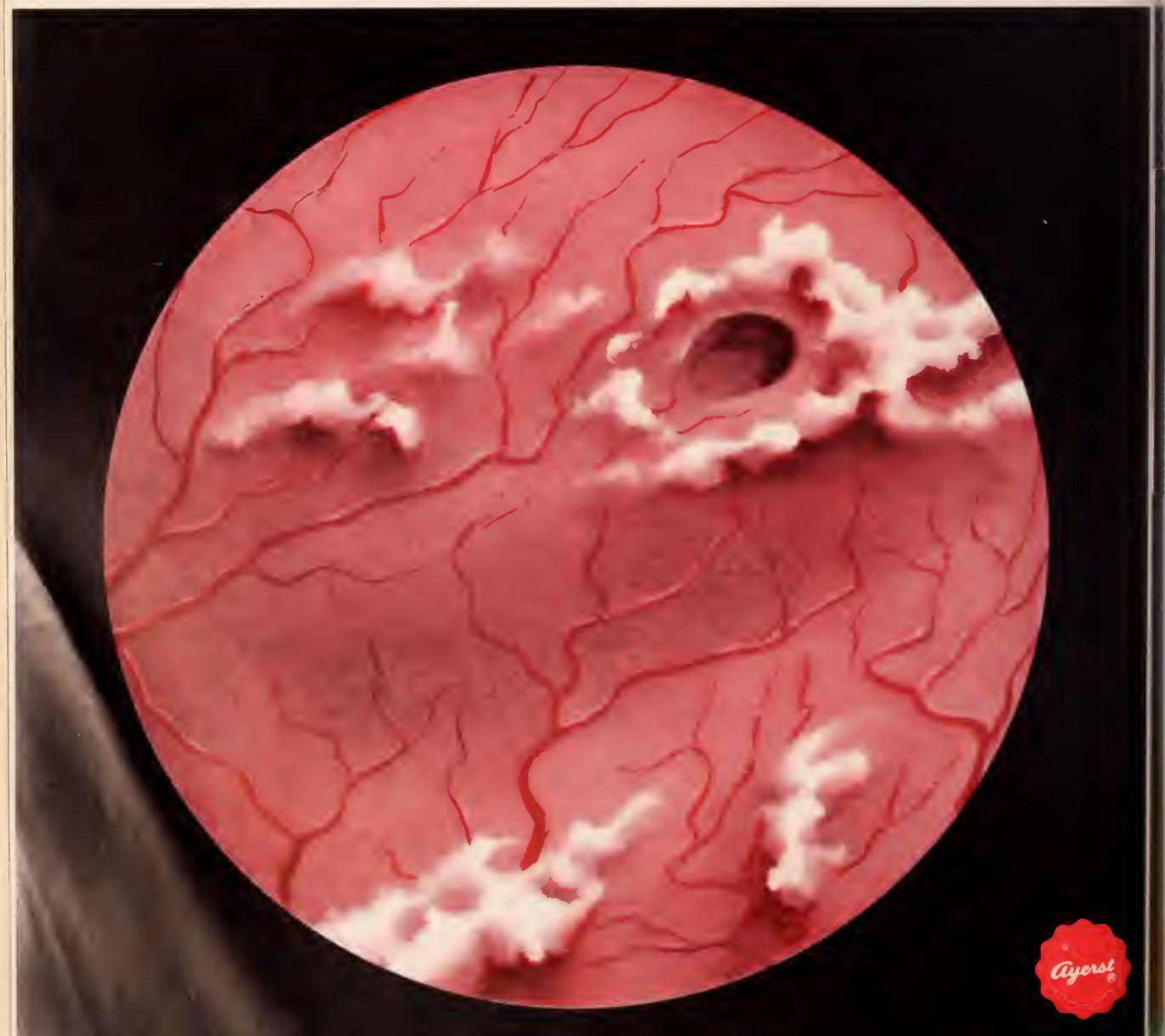
5737

Single sulfonamide specifically for urinary tract infections —unexcelled in long-term therapy. Gram for gram "Thiosulfil" is unexcelled for effective bacteriostatic action against a broad variety of urinary tract pathogens. High solubility, complete absorption, minimal acetylation, and negligible penetration into red blood cells ensure rapid and effective action with minimal side effects.

Ayerst Laboratories • New York, N. Y. • Montreal, Canada

direct / effective **"THIOSULFIL"®**

(Brand of sulfamethizole)



FOR THE ENTIRE RANGE OF RHEUMATIC-ARTHRITIC DISORDERS—from the mildest to the most severe

many patients with **MILD** involvement can be effectively controlled with

'MEPROLONE'

many patients with **MODERATELY SEVERE** involvement can be effectively controlled with

'MEPROLONE'

NEW

and **NOW** for patients with **SEVERE** involvement

MULTIPLE COMPRESSED TABLETS

'MEPROLONE'

The only meprobamate-prednisolone therapy



the one antirheumatic, antiarthritic that simultaneously relieves: (1) muscle spasm (2) joint inflammation (3) anxiety and tension (4) discomfort and disability.

SUPPLIED: Multiple Compressed Tablets in three formulas: 'MEPROLONE'-5—5.0 mg. prednisolone, 400 mg. meprobamate and 200 mg. dried aluminum hydroxide gel. 'MEPROLONE'-2—2.0 mg. prednisolone, 200 mg. meprobamate and 200 mg. dried aluminum hydroxide gel. 'MEPROLONE'-1 supplies 1.0 mg. prednisolone in the same formula as 'MEPROLONE'-2.

MSD MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.

'MEPROLONE' is a trademark of Merck & Co., Inc.



assure her

a more serene, a happier pregnancy

. . . without nausea

give her **'MAREDOX'®** brand

Cyclizine Hydrochloride and Pyridoxine Hydrochloride

because 'Maredox' gives the expectant mother new-found relief from morning sickness.

relieves nausea and vomiting and *counteracts pyridoxine deficiency* — *in pregnancy*

One tablet a day, taken either on rising or at night, is all that most women require.

Each tablet of 'Maredox' contains:
'Marezine'® brand Cyclizine Hydrochloride..... 50 mg.
Pyridoxine Hydrochloride ..... 50 mg.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

KNOX PROTEIN PREVIEWS

Overcoming Today's No. 1 Nutritional Problem



Knox "Choice of Foods" Diet Can Help Your HYPERTENSIVE Patients to Reduce and Stay Reduced



1. Color coded diets of 1200, 1600 and 1800 calories are based on nutritionally tested Food Exchanges.[1]

2. The easy-to-use Food Exchanges (called Choices in booklet) simplify diet management by eliminating calorie counting.

3. Diets promote accurate adjustment of caloric levels to the special needs of the patient yet allow each individual considerable latitude in the choice of foods.

4. More than six dozen appetizing, low-calorie recipes are described in the last fourteen pages of the diet booklet.

1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc., and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.



Chas. B. Knox Gelatine Co., Inc.
Professional Service Dept. SJ-26
Johnstown, N. Y.

Please send me ..... dozen copies of the new, illustrated Knox Reducing booklet based on Food Exchanges.

Your Name and Address.

Meat...

and the Need for Adequate Protein in Therapeutic Nutrition

Liberal protein intake is considered to be of therapeutic value in a wide variety of pathologic conditions.[1] Advances in the understanding of protein metabolism indicate that dietary protein should provide amino acids in proportions paralleling physiologic needs.[2, 3] In experimental studies with animals, low protein diets supplying amino acids disproportionate to needs have been shown to effect physiologic harm by depressing growth, by inducing amino acid and B-vitamin deficiencies, and by causing deposition of fat in the liver.[4]

Hence not only the *amount* of protein but also its *quality* (in terms of its amino acid proportions) is important. It has been suggested[1] that for therapeutic purposes about two-thirds of the ingested protein come from foods of animal source, whose protein resembles human body protein in amino acid interrelationships. Depending on the needs of the patient, the therapeutic diet may supply 1.0 or more grams of protein per kilogram of body weight. Adequate caloric intake is required to protect the dietary protein from dissipation for energy purposes.

Meat, with its high content of top-quality protein, holds a prominent place among foods which supply this essential for establishing satisfactory levels of amino acids in physiologic proportions. It also contributes valuable amounts of B vitamins and essential minerals—nutrients which play a basic role in intermediate metabolism.

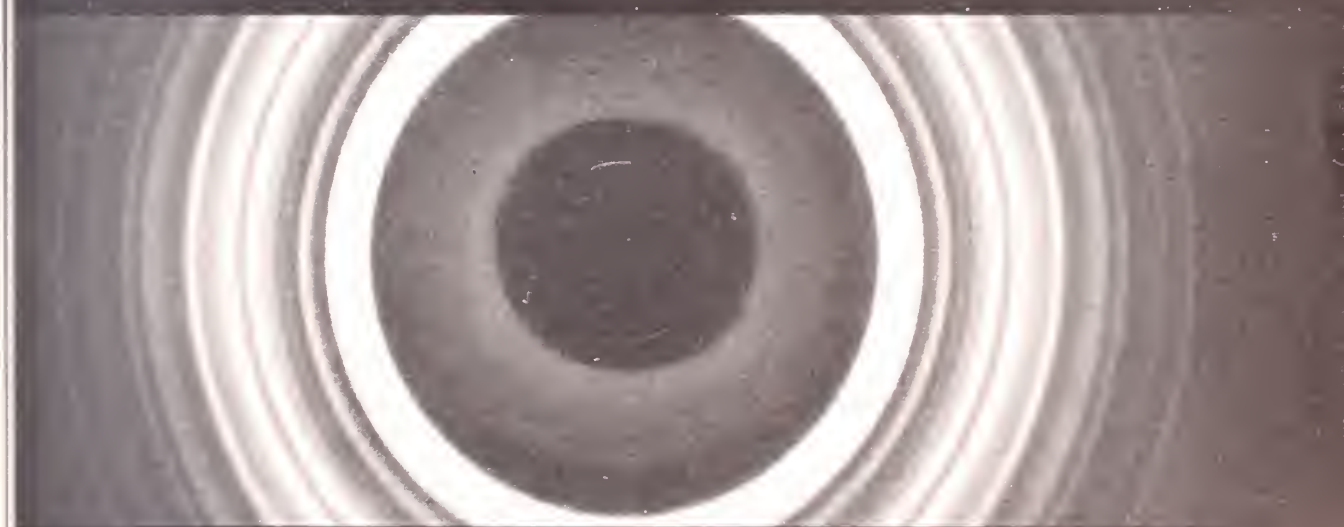
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1. Proudfit, P. T., and Robinson, C. H.: Nutrition and Diet Therapy, ed. 11, New York, The Macmillan Company, 1955, pp. 314-320.
2. Harper, A. E.: Amino Acid Imbalance, Toxicities and Antagonisms, Nutrition Rev. *14*:225 (Aug.) 1956.
3. Amino Acid Requirements of Adult Man, Nutrition Rev. *14*:232 (Aug.) 1956.
4. Amino Acid Imbalance and Supplementation, Editorial, J.A.M.A. *161*:884 (June 30) 1956. Council on Foods and Nutrition, American Medical Association: Importance of Amino Acid Balance in Nutrition, J.A.M.A. *158*:655 (June 25) 1955.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

American Meat Institute
Main Office, Chicago... Members Throughout the United States

PARKE-DAVIS ANNOUNCES A MAJOR ADVANCE IN FEMALE HORMONE THERAPY



▲ The x-ray diffraction pattern of NORLUTIN distinguishes its crystal structure from that of other progestogens.

NORLUTIN T.M.

(norethindrone, Parke-Davis)

oral progestational agent with unequalled potency and unsurpassed efficacy

UNEQUALLED POTENCY

for oral progestational therapy



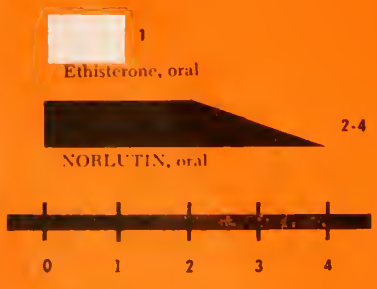
NORLUTIN
(17-alpha-ethinyl-19-
nortestosterone)

NORLUTIN is an example of "...increased biological activity of a steroid when the methyl group at carbon 10 is replaced with hydrogen."[1]

NORLUTIN

INDICATIONS FOR NORLUTIN: amenorrhea, menstrual irregularity, functional uterine bleeding, infertility, habitual abortion, threatened abortion, premenstrual tension, dysmenorrhea.

RELATIVE POTENCIES OF ETHISTERONE AND NORLUTIN IN HUMANS[2,3]



REFERENCES: (1) Hertz, R.; Tullner, W., & Raffelt, E.: *Endocrinology* 54:228, 1954. (2) Greenblatt, R. B.: *J. Clin. Endocrinol.* 16:869, 1956. (3) Hertz, R.; Waite, J. H., & Thomas, L. B.: *Proc. Soc. Exper. Biol. & Med.* 91:418, 1956. (4) Tyler, E. T.: *J. Clin. Endocrinol.* 15:881, 1955. (5) Greenblatt, R. B., & Clark, S. L.: M. Clin. North America, Philadelphia, W. B. Saunders Co. (Mar.) 1957, p. 587.

PACKAGING: 5 mg. scored tablets (C. T. No. 882), bottles of 30.

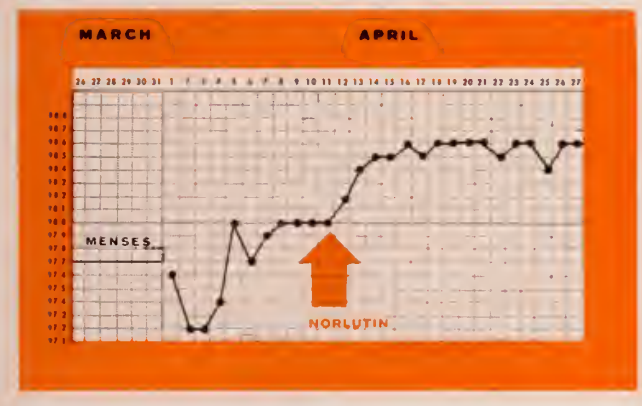
UNSURPASSED EFFICACY

in disorders of menstruation and pregnancy



NORLUTIN: Progestational Effect on Endometrium "...10 mg. [NORLUTIN] given twice daily represents a reproducibly effective dose in women for the production of marked progestational changes in the endometrium."[3]

◀ Presecretory to secretory endometrium after 5 days treatment.



NORLUTIN: Thermogenic Effect "This preparation was found to have a marked thermogenic, and other physiologic effects in comparatively small dosage."[4]



NORLUTIN: Abolition of Arborization in Cervical Mucus NORLUTIN "...inhibits the fern leaf pattern in cervical mucus."[5]

◀ 1. Fern leaf pattern. 2. Arborization completely abolished by NORLUTIN.

NORLUTIN: Induction of Withdrawal Bleeding "As little as 50 mg. of [NORLUTIN] administered in divided doses over a five-day period was sufficient to induce withdrawal bleeding."[2]

MEDICAMENTA VERA

PARKE, DAVIS & COMPANY · DETROIT 32, MICHIGAN

50172

If you could visit



with a user of the Picker Anatomatic Century x-ray unit you'd soon know why this remarkable "new way in x-ray" machine has come so far so fast.

He'd probably tell you first how incredibly easy it is to use (just dial the body part and set its thickness... then press the button). He might sigh with relief at having no charts to consult, no calculations to make (the anatomatic principle does all the tedious "figgerin" for you).



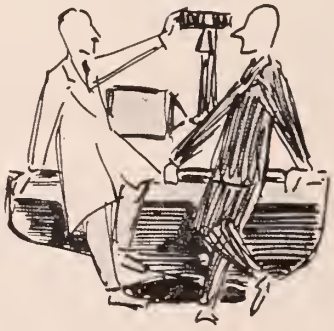
He'd probably show you how good a radiograph he gets every time





He might even touch on the peace-of-mind that comes of having a local Picker office so near, with a trained Picker expert always on call for help and counsel

and there'd be no mistaking the light in his eye when it falls on the handsome big-name unit whose fine appearance adds so much to the impressiveness of his office.



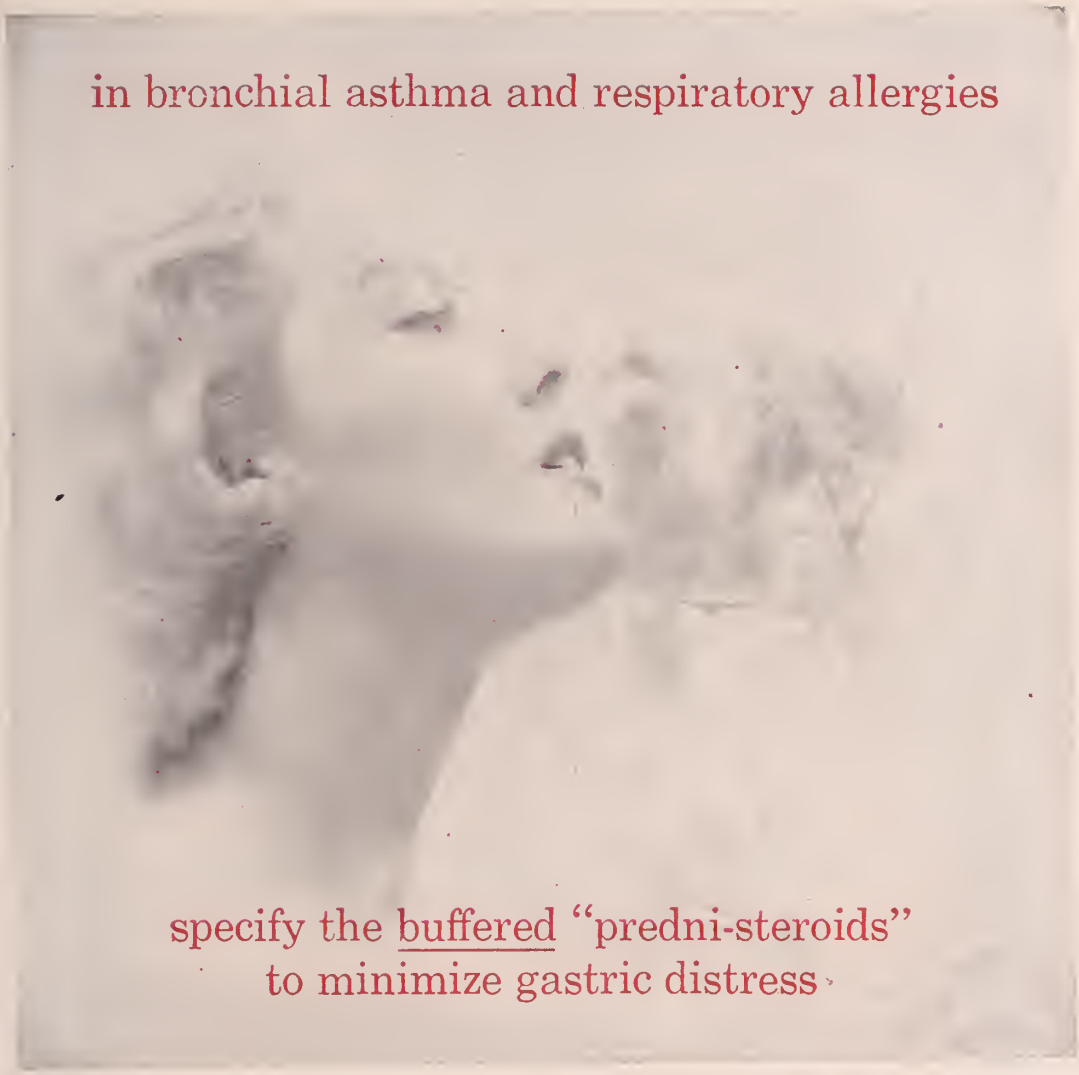
P.S. Somewhere along the line the matter of price would come up ... he'd most likely comment on how little he paid to get so much. Or he might even be among those who rent their x-ray machine (Picker has an attractive rental plan, you know).

P.P.S. Next best thing is to call your local Picker man in and let him tell you about this great new machine (find him in your 'phone book) or write Picker X-Ray Corporation, 25 South Broadway, White Plains, N. Y.

NEWARK 2, N. J., 9/2 Broad Street
Lincoln Park, N. J., 10 Nakomis Avenue
Arlington, N. J., 186 Belville Pike

Matawan, N. J., 52 Edgemere Drive
Philadelphia 4, Pa., 103 S. 34th St.
(Southern N. J.)

in bronchial asthma and respiratory allergies



specify the buffered "predni-steroids"
to minimize gastric distress

combined steroid-antacid therapy . . .

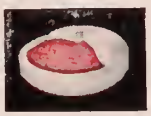
Co-Deltra®
(Prednisone buffered)

Co-Hydeltra®
(Prednisolone buffered)

'Co-Deltra' or 'Co-Hydeltra' provides all the benefits of "predni-steroid" therapy and minimizes the likelihood of gastric distress which might otherwise impede therapy. They provide easier breathing—and smoother control—in bronchial asthma or stubborn respiratory allergies.

SUPPLIED: Multiple Compressed Tablets 'Co-Deltra' or 'Co-Hydeltra' in bottles of 30, 100, and 500.

Multiple Compressed Tablets



2.5 mg. or 5.0 mg. of prednisone or prednisolone, plus 300 mg. of dried aluminum hydroxide gel and 50 mg. of magnesium trisilicate.

'CO-DELTRA' and 'CO-HYDELTRA' are registered trademarks of MERCK & CO., INC.

MSD

MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.

effective vulvovaginal therapy

trichotine®

a detergent . . . a bactericide and fungicide . . .
an antipruritic . . . an aid to epithelization . . .
an aesthetic and psychosomatic adjunct

Trichotine douches — incorporating the multiple advantages of sodium lauryl sulfate with the recognized values of other specific or adjunctive agents — may be prescribed as often as required in cases of nonspecific vaginitis and leukorrhea, subacute and chronic cervicitis, senile vaginitis, trichomoniasis, and moniliasis; hot packs are often quickly effective in pruritus vulvae.

Concentrated solutions are useful for clean-up or swab treatment in the physician's office.

VACID

the 24-hour vaginal pH stabilizer

The therapeutic value of continual maintenance of normal vaginal pH (4.0 to 4.5) is widely recognized in the treatment of monilial, trichomonal, and nonspecific bacterial infections and in cervicitis.

One Vacid insert suppository will hold the pH of the vagina at the normal physiologic level for 24 hours. Symptomatic relief is noted usually the first day and progressive improvement continues until Doderlein bacilli replace the infecting organisms — usually within 7-14 days.

Samples and literature on request . . . Full details in PDR.

The Fesler Co., Inc. Stamford, Conn.



. . . ICE MILK !

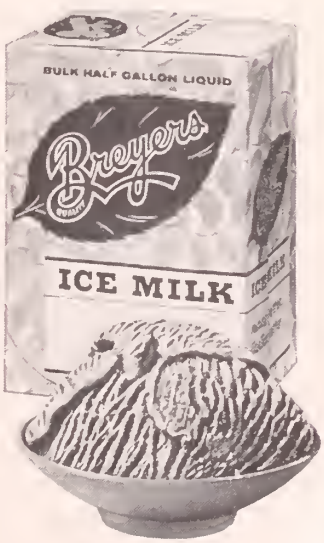
Keep fat down with Breyers Ice Milk!

- HIGH PROTEIN VALUE!
- LOW CALORIE CONTENT!

Your ice cream-loving patients will welcome this delightful, frozen treat in which Breyers famed quality flavors are blended with *milk* instead of cream!

Regular ice cream contains 44% more calories! And in some special brands, this variation in caloric content is even greater.

Available wherever Breyers Ice Cream is sold.



among nonhormonal antiarthritics...
unexcelled in
therapeutic potency

BUTAZOLIDIN®

(phenylbutazone GEIGY)

In the nonhormonal treatment of arthritis and allied disorders no agent surpasses BUTAZOLIDIN in potency of action.

Its well-established advantages include remarkably prompt action, broad scope of usefulness, and no tendency to development of drug tolerance. Being nonhormonal, BUTAZOLIDIN causes no upset of normal endocrine balance.

BUTAZOLIDIN relieves pain, improves function, resolves inflammation in:
Gouty Arthritis
Rheumatoid Arthritis
Rheumatoid Spondylitis
Painful Shoulder Syndrome

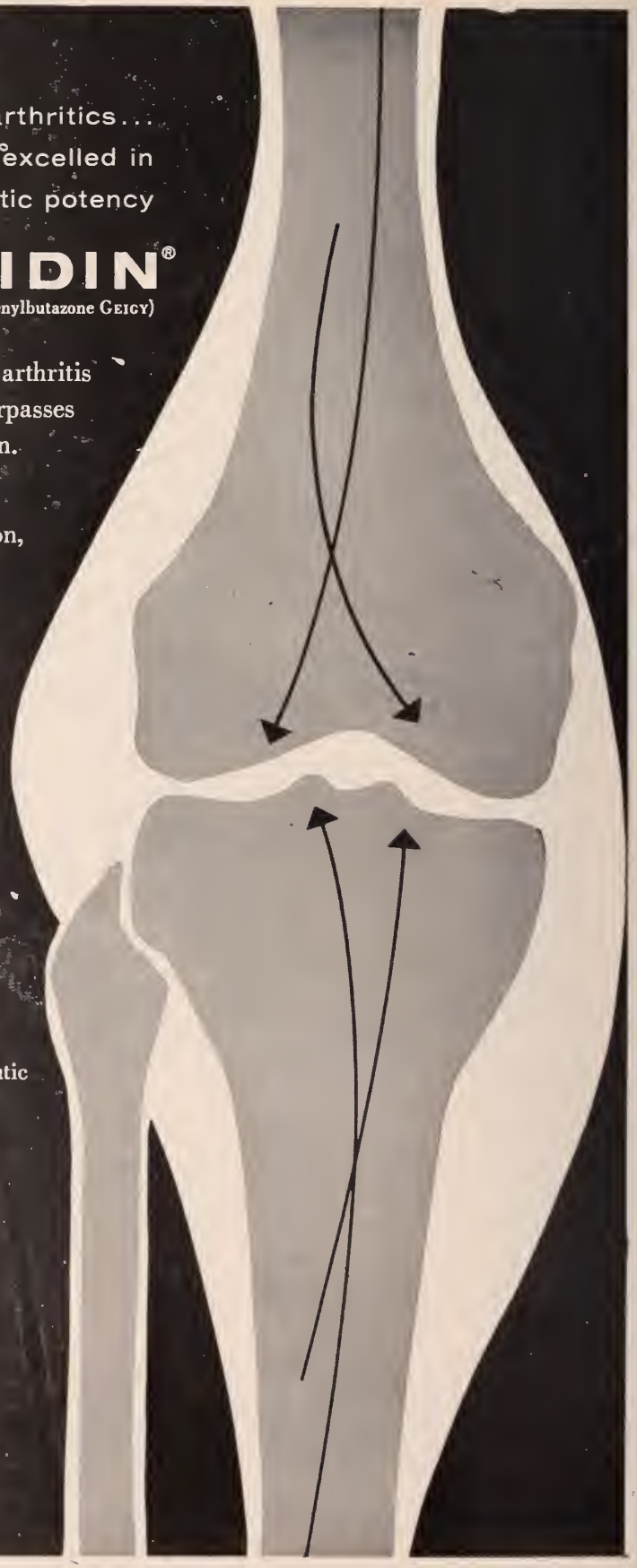
BUTAZOLIDIN being a potent therapeutic agent, physicians unfamiliar with its use are urged to send for detailed literature before instituting therapy.

BUTAZOLIDIN® (phenylbutazone GEIGY). Red coated tablets of 100 mg.

GEIGY

Ardsley, New York

77997





WHENEVER COUGH THERAPY IS INDICATED

Hycodan®

(Dihydrocodeinone with Homatropine Methylbromide)

- Relieves cough quickly and thoroughly
- Effect lasts six hours and longer, permitting a comfortable night's sleep
- Controls useless cough without impairing expectoration
- rarely causes constipation
- And pleasant to take

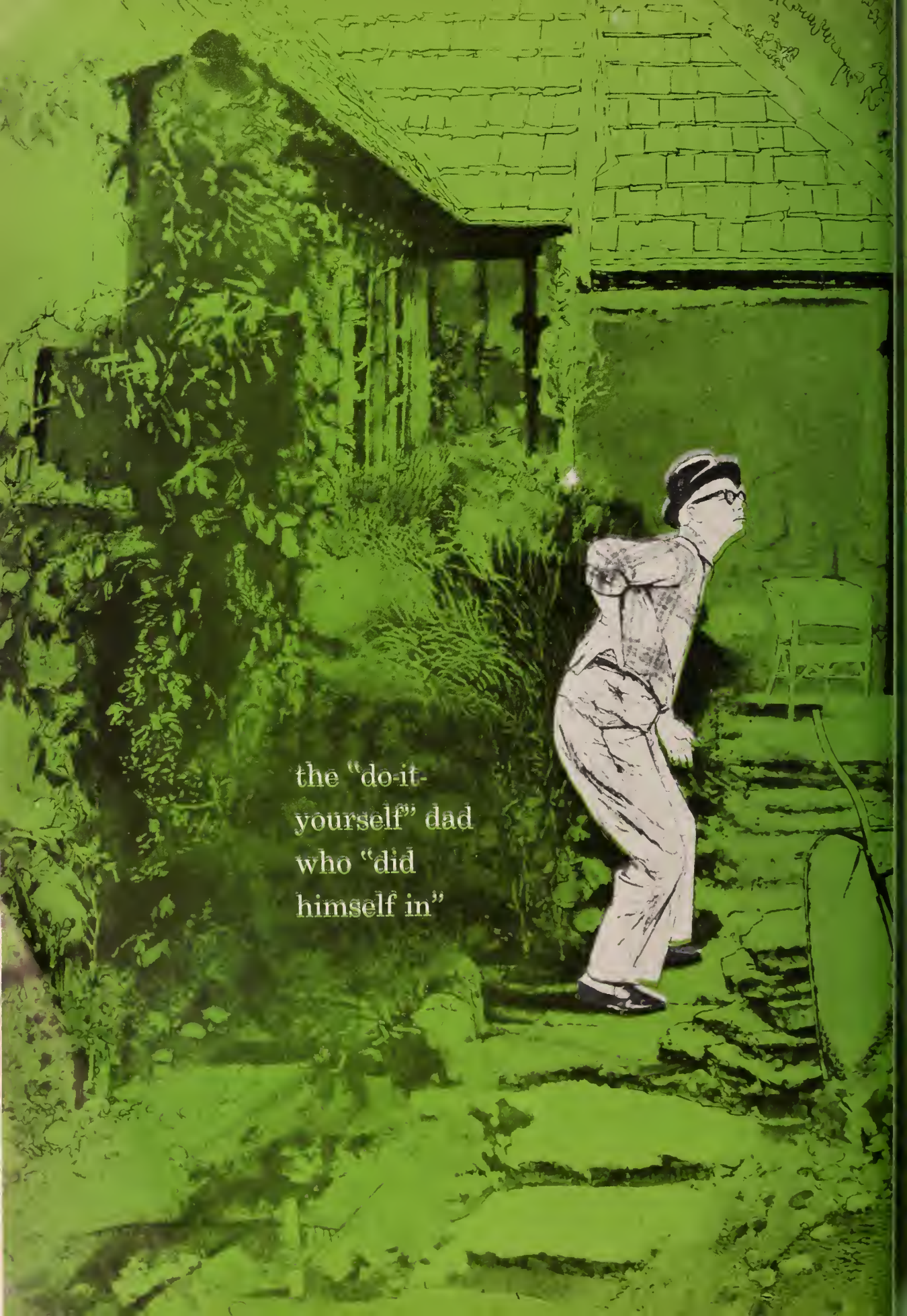
Syrup and oral tablets. Each teaspoonful or tablet of HYCODAN* contains 5 mg. dihydrocodeinone bitartrate and 1.5 mg. Mesopin.† Average adult dose: One teaspoonful or tablet after meals and at bedtime. May be habit-forming. Available on your prescription.

Endo®

ENDO LABORATORIES
Richmond Hill 18, New York

*U. S. PAT. 2,630,400

† BRAND OF HOMATROPINE METHYLBROMIDE


the "do-it-
yourself" dad
who "did
himself in"

lumbago

For persons who overestimate their physical capacity —as with this do-it-yourself dad—chronic fibrositis may be a postscript to a weekend of accomplishment.

SIGMAGEN therapy is encouraged in the treatment of chronic fibrositis to alleviate pain and prevent progression of the disorder to fibrosis and calcification.

SIGMAGEN provides doubly protective corticoid-salicylate therapy. METICORTEN® (prednisone) and acetylsalicylic acid are combined to provide additive antirheumatic benefits and rapid analgesic effect. These dual clinical values are enhanced by aluminum hydroxide to counteract excess gastric acidity and by ascorbic acid to help meet the increased need for this vitamin during stress situations.

Therapy should be individualized. *Acute conditions:* 2 or 3 tablets 4 times daily. Following desired response, gradually reduce daily dosage and discontinue. *Subacute or chronic conditions:* Initially as above. After satisfactory control is obtained, gradually reduce the daily dosage to minimum effective maintenance level. For best results administer after meals and at bedtime.

Precautions: Because SIGMAGEN contains prednisone, the same precautions and contraindications observed with this steroid apply also to the use of SIGMAGEN.

for patients who go beyond their physical capacity

protective corticoid-salicylate therapy

SIGMAGEN®

corticoid-analgesic compound Tablets

Prednisone	0.75 mg.	Aluminum hydroxide	75 mg.
Acetylsalicylic acid	325 mg.	Ascorbic acid	20 mg.

SG-J-587

Schering

for "This Wormy World"



Pleasant tasting

'ANTEPAR'® brand

PIPERAZINE

SYRUP · TABLETS · WAFERS

Eliminate **PINWORMS IN ONE WEEK**
ROUNDWORMS IN ONE OR TWO DAYS

PALATABLE • DEPENDABLE • ECONOMICAL

'ANTEPAR' SYRUP – Piperazine Citrate, 100 mg. per cc.
'ANTEPAR' TABLETS – Piperazine Citrate, 250 or 500 mg., scored
NEW **'ANTEPAR' WAFERS** – Piperazine Phosphate, 500 mg.

Literature available on request

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

optimal dosages for ATARAX,
based on thousands of case histories:

25 *mg. (t.i.d.)*

for these **25** *adult indications:*

TENSION · SENILE ANXIETY · MENOPAUSAL SYNDROME · ANXIETY · PREMENSTRUAL TENSION
PHOBIA · HYPOCHONDRIASIS · TICS · FUNCTIONAL G. I. DISORDERS · PRE-OPERATIVE ANXIETY
HYSTERIA · PRENATAL ANXIETY · AND ADJUNCTIVELY IN CEREBRAL ARTERIOSCLEROSIS
PEPTIC ULCER · HYPERTENSION · COLITIS · NEUROSES · DYSPNEA · INSOMNIA
PRURITIS · ASTHMA · ALCOHOLISM · DERMATITIS · PARKINSONISM · PSORIASIS

perhaps the safest ataraxic known

PEACE OF MIND ATARAX® *Tablets-Syrup*

(BRAND OF HYDROXYZINE)

10 *mg. (t.i.d.)*

for these **10** *pediatric indications*

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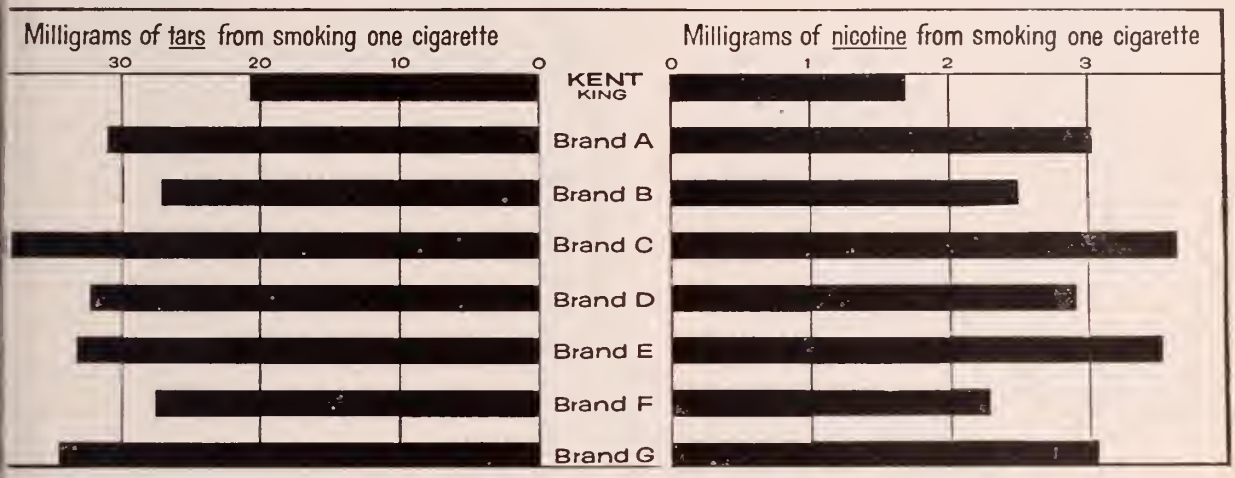
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"...by far the most effective

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1. Locket, S.: Brit. M.J. *1*:809 (Apr. 2) 1955.

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2. Wright, W.T., Jr., et al.: J. Kansas M. Soc. *57*:410 (July) 1956.

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REFERENCES

1. Freed, S. C., and Mizel, M.: Annals of Int. Med., June, 1952.
2. Dripps, R. D.: J.A.M.A. 139:148-150 (Jan. 15), 1949.

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Infant Carbohydrate Metabolism

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2	625		
3	675		
4	725	110	50
5	750		
6	800		
7	825	100	45
8	850		
9	875		
10	900	95	43
11	950		
12	1000		
24	1200	90	40



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(Iproniazid) 'Roc

Marsilid 'Roche' is a psychic energizer—the very opposite of a tranqui
It is useful not only for mild and severe depression but for stimulatic
appetite and weight gain, and in chronic debilitating disorders.

Q. What is Marsilid?

A. Marsilid (iproniazid) is an amine oxidase inhibitor which at
the metabolism of serotonin, epinephrine, norepinephrine and other an

Q. How does Marsilid act?

A. Marsilid has a normal eudaemonic* rather than an abnorm
phoric effect; it promotes a feeling of well-being and increased vital
restores depleted energy and stimulates appetite and weight gain in c
debilitating disorders.

Q. How soon is the effect of Marsilid apparent?

A. Marsilid is a slow-acting drug. In mild depression it usually
effect within a week or two; in severe psychotics, results may be appare
after a month or more.

Q. What are the indications for Marsilid?

A. Mild depression in ambulatory, non-psychotic patients; psy
associated with severe depression or regression; stimulation of appeti
weight gain in debilitated patients; chronic debilitating disorders; stim

*Eudaemonia is a feeling of well-being or happiness; in Aristotle's use, felicity r
from life of activity in accordance with reason.

psychic energizer

(the opposite of a tranquilizer)

of wound healing in draining sinuses (both tuberculous and non-tuberculous); adjunctive therapy in rheumatoid arthritis when associated with depressed psychomotor activity (Marsilid stimulates physical and mental activity, appetite and weight gain without objective joint changes).

Q. What is the dosage of Marsilid?

A. The daily dose of Marsilid should not exceed 150 mg (50 mg t.i.d.). In patients who are not hospitalized, the dosage should be reduced after the first 8 weeks to an average of 50 mg daily or less, for Marsilid is a cumulative drug. Like all potent drugs, Marsilid requires careful individual dosage adjustment.

Q. What are the potential side effects of Marsilid?

A. Side effects due to Marsilid are reversible upon reduction of dosage or cessation of therapy. It may cause constipation, hyperreflexia, paresthesias, dizziness, postural hypotension, sweating, dryness of mouth, delay in starting micturition, and impotence.

Q. When is Marsilid contraindicated?

A. Marsilid is contraindicated in overactive, overstimulated or agitated patients. Marsilid therapy should be discontinued two days before the use of ether anesthesia. It should not be given together with cocaine or meperidine. In patients with impaired kidney function, Marsilid should be used cautiously to prevent accumulation. Marsilid is not recommended in epileptic patients.

Q. How is Marsilid supplied?

A. Marsilid is supplied in scored 50-mg, 25-mg and 10-mg tablets.

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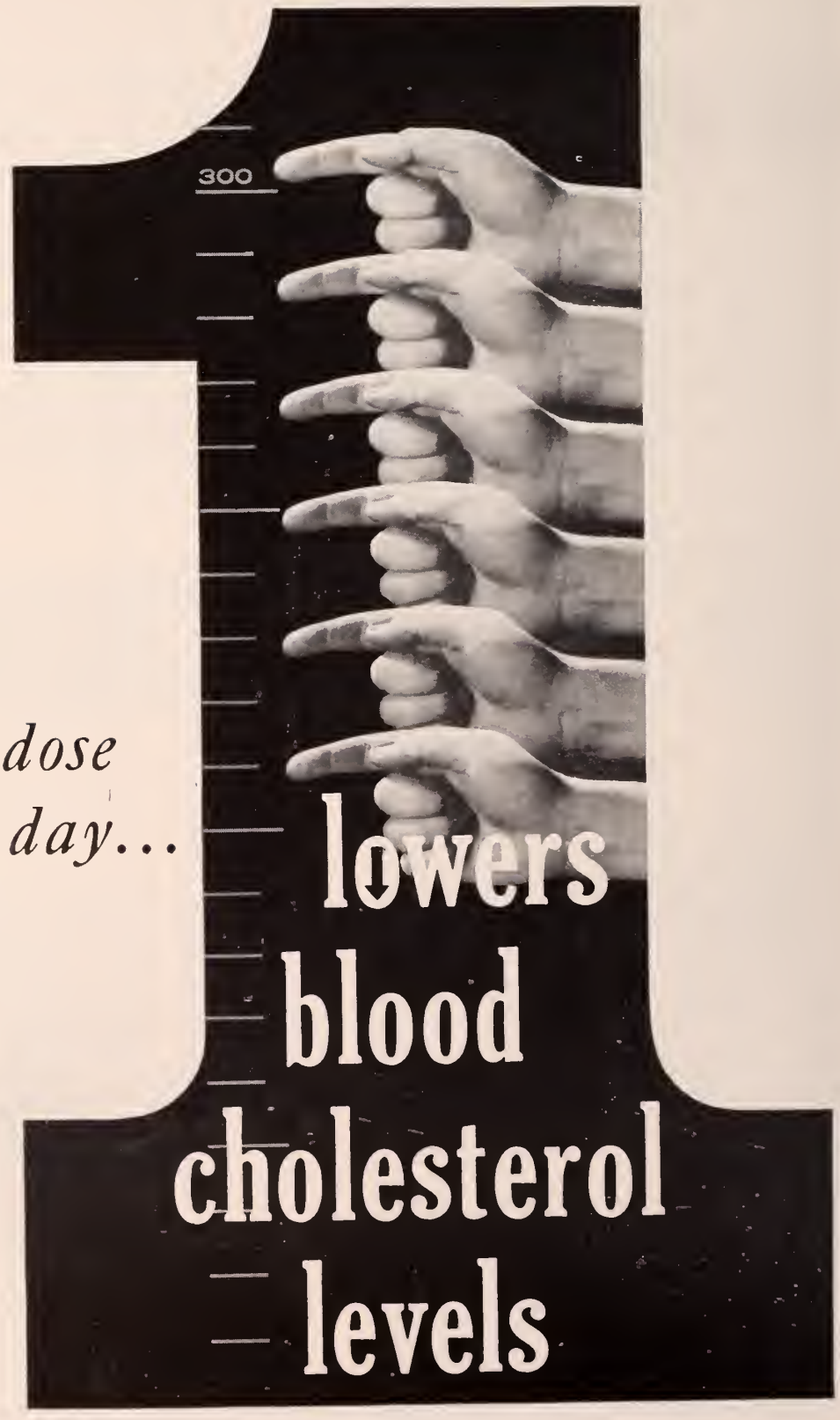
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†Ayd, F. J., Jr.: The Treatment of Ambulatory and Hospitalized Psychiatric Patients with Trilafon, presented at Ann. Meet., Am. Psychiat. Assoc., Chicago, Ill., May 13-17, 1957.

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THE JOURNAL
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Editorials • • •

What Price Patient's Responsibility?

The current trend is to emphasize the patient's responsibility for treatment. For certain chronic illnesses, such as diabetes, mucous colitis, and some of the psychoneuroses, good prognosis correlates well with the patient's willingness to take active responsibility in treatment. This is also used as an argument in favor of compulsory health insurance. The theory is that the patient ought to be compelled, if necessary, to assume some financial responsibility for his own medical care. Instead of letting him become a charge on the community, on relatives, or on the charity of physicians, insist that he set aside some money every pay day to buy health insurance. This is, in a way, a queer reversal of roles. The people who favor compulsory insurance are usually thought of as "liberal" and "welfare minded." In this thesis, the proponent of compulsory insurance speaks that way because he objects to too much liberalism and liberality.

Be that as it may, there is increasing emphasis on patient responsibility for carrying out a therapeutic program. At first it does seem as if the patient should share in therapeutic responsibility. The reverse, certainly, is untenable: you cannot expect a physician to make progress with a resistant and non-cooperative patient. With respect to the patient's assumption of part of the therapeutic burden, however, there is something to be said *contra*. When a patient retains a doctor, one of the things he is paying him for, is to take over the responsibility. One of the reasons doctors get deference is that they assume awesome responsibilities. If a sick physician is to be considered a "good patient," his goodness will consist of his not wanting to know what medication he is getting, or even what the laboratory tests show. The hope is that he will abandon all such responsibility to *his* attending physician—rather than add to his own burdens. This is surely true, *a fortiori*, of the non-professional patient.

Part of the healing effectiveness is the patient's faith in the physician's magical powers. 'Everything is now all right. The doctor is here." We physicians know that we do not always deserve such acceptance . . . but we also know that this kind of faith contributes

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to the healing process. Implicit in this faith is the patient's willingness to relax while the doctor makes the decisions. A physician might say: "You ought to lose weight, but you should not frustrate yourself by too much denial. Think it over and decide whether the frustration is more bothersome than the obesity." Or he might say: "This new medication will lower your blood pressure but it will also make you a bit sluggish. Do you prefer it that way?" In each case, the patient has to shoulder the burden that he is paying the doctor to carry. What the patient wants (even if he says otherwise) is a clean-cut, definite, spelled out program to follow. He does not really want to be a member of a steering committee to decide on the next course. He wants to be free of the weight of decision-making.

So the doctor must decide. And no matter how many consultants he has, the treating physician must, in the last analysis, make the decision solo. And he must take full responsibility for it. It is a lonesome, and sometimes terrible load. But who ever undertakes to treat the sick assumes just that burden.

The Fetish of the Team

One of the catch words of modern medicine is 'team." It has come to be taken for granted that a coordinated group can do better work—whether in research, diagnosis, teaching or treatment—than an individual. Take research for instance. A century ago, research meant a genius laboring alone in a crude attic or cellar work-shop. Today it is done in a chromium plated laboratory by a team of physicists, biologists, physiologists and statisticians, with money provided by a Foundation, leading to a committee-written report, that concludes by stressing the need for further research. So with diagnosis. Our medical grandfathers listened through a stethoscope, boiled the urine, palpated the abdomen, smelt the breath, squinted through a microscope and thought out a diagnosis. Today, the interesting diagnoses are made only after a whole team has come in on the act. The major teaching device in this era is the panel discussion, the seminar, the case conference or the colloquium instead of the impressive explanation given by an inspired pedagogue. And for therapy, the group and the clinic are rapidly replacing the individual practitioner.

Even those who nostalgically yearn for the good old days, will say that this is an improvement. After all, it is argued, two heads are better than one. And out of the meeting of mind against mind come the sparks of new ideas. So it says in the conference leaders' manual. And, of course, in union there is strength.

Actually, however, there is no scientific proof that this is so. On the contrary, it is doubtful if a group can create a single new idea. Out of a case presentation may come a correct diagnosis. But it comes out of one member's head. Indeed, it may even be that the group has a dampening effect on creative thinking. The lone genius in the team who has the correct but unconventional idea hesitates to expose himself to ridicule. And no one wants to be known as a stubborn agitator or bull-headed objector. The group can be a tyrant in more ways than one.

This is not to derogate the value of consultation. There is, however, a vast difference between a one-to-one consultation and a group-engineered decision. The general practitioner may solicit a specialist's opinion on a puzzling case and integrate that opinion with his own judgment. The treating physician retains responsibility and control. In its modern sense, however, the anonymous group has control and no one individual has responsibility. The aim of a staff meeting, under today's practice, is agreement. And the need for agreement inhibits the creative drive.

The physician's team has widened. Once the para-medical person proudly carried the adjective *ancillary*. Ancilla means "handmaiden." Today the concept has changed from that of a physician-controlled hierarchy to that of a team of colleagues working together. The nurse has moved from *ancilla* to partner, corresponding perhaps to her movement from the bedside to the desk. The technician, the social worker, the occupational therapist, the psychologist, the chiropodist, the dietetian and all the others now play ball on the same team, and the physician is lucky if they let him function as a quarterback and call the signals.*

Medicine is not alone in this obeisance to the team fetish. Time was when businesses and colleges were headed by giants whose names you knew—whether it was Henry Ford or Nicholas Murray Butler, whether you liked him or not, you knew that top decisions were made by a single leader and not by a caucus of invisible men. So with churches, professional groups, government and other callings.

Maybe he travels the swiftest who travels alone. But travelling in a group seems a lot more secure, and that's what counts these days. Abandon individual responsibility: share it with the team.

Blue Shield and the Economics of Medicine

The physician has a vital professional stake in the success of his own medical pre-payment Plan. This Plan demonstrates the doctor's determination to solve the basic problems of medical economics on terms that will assure a continuing opportunity to give his patients the best of care.

Second, the Blue Shield Plan accounts for an increasing part of the doctor's income. He will want to make sure that Blue Shield provides him with reasonable payments for the services that Blue Shield promises to pay for.

Third — and perhaps most important — only through Blue Shield can the medical profession continue to control the economy of medical practice.

Blue Shield pioneered the development of pre-paid medical care. While many other agencies provide cash benefits for medical services on an expanding scale, only Blue Shield—because of its intimate relationship to organized medicine—is consistently trying to relate its benefits to the physician's normal charges. Only Blue Shield—because of its non-profit organization—has as its basic purpose the provision of maximum service to the patient, with an adequate compensation to the doctor. Any "profit" from Blue Shield operations goes to the patient in broader benefits, or to the physician in more adequate payment—not to a third party.

If other organizations unrelated to the medical profession were to take over the entire voluntary prepayment program, then control of the basic economy of American medicine would pass completely out of the hands of the medical profession.

Blue Shield is big. Over 37 million people are enrolled and more than $350 millions are paid each year in medical benefits by the Plans. But Blue Shield is big only because the medical profession has fashioned a big instrument to do a big job—and the public has given Blue Shield a big reception!

Blue Shield can never be bigger than the profession that created it. It is yours, doctor, to mould and shape as you will, for the greater good of the people you serve.

**Correction*: There is one time they do let the M.D. take over. When the patient sues for malpractice.

W. Alan Wright, M.D.

Montclair

Action and Uses of Ataractic Compounds*

A CRITIQUE

The major booby trap in medical research is evaluating "subjective" improvement. This difficulty has cast doubt on the ultimate value of the widely advertised "tranquilizers." Dr. Wright here suggests a formula for minimizing this difficulty.

Many potent drugs have been developed in recent years that looked promising enough in the laboratory to warrant clinical trial to determine their safety and efficacy in patients. Clinical procedures to evaluate the safety and efficacy of drugs have evolved over the years and have become to some extent standardized. The procedures in general use today are admirably suited to the evaluation of antimicrobial agents, antihypertensive agents, and other drugs whose effects are objective and easily measured.

These procedures are applicable only in part, however, to the evaluation of drugs the effects of which are largely subjective—effects which can be measured only with difficulty. We are now harvesting a rich crop of such compounds, the ataractic or tranquilizing drugs, and there are prospects of more to come.

Ataractic drugs may produce objective and easily measured effects, but these are of only limited value in determining their whole range of effectiveness. Many of their clearest and most objective effects are undesirable side reactions, such as the obstructive jaundice occasionally produced by chlorpromazine. While it is fortunate that effects such as this can be detected by standard clinical procedures, the question of therapeutic efficacy remains.

Objective effects that are desirable may be elicited under special conditions. For instance, certain somatic diseases in which anxiety is a contributing factor may respond to ataraxics in ways that are easily measurable. Warter [1] has recently demonstrated that rheumatoid arthritis patients may require lower maintenance doses of steroids when they are receiving an ataractic drug concomitantly. The change in steroid requirements is an objective phenomenon, easy to measure, and easy to analyze quantitatively. Relatively few patients are necessary to demonstrate a significant effect. It may well develop that the effectiveness of ataractic drugs will generally be easiest to demonstrate in physical disorders that are caused or exacerbated by emotional stress. Work has already been done suggesting that one or another of them may be effective in peptic ulcer, chronic ulcerative colitis, hypertension, atopic dermatitis, localized neurodermatitis, anogenital pruritus and other der-

*Presented before the general session on medicine at the Annual Meeting of The Medical Society of New Jersey in Atlantic City, April 29, 1957.

matologic disorders, and "psychogenic rheumatism."

In addition, the administration of ataraxics may cause objective changes in behavior. These changes should be susceptible to measurement, and such measurements have been attempted in psychotic patients, whose behavior may be strikingly improved by ataractic drugs. However, these efforts have not produced entirely satisfactory results. The available standard tests do not seem to distinguish reliably between the effects of a potent agent and that of suggestion, as when a potent agent is compared with a placebo. It is the consensus of investigators that the difficulty lies in the inadequate design of the tests used rather than the ataractic drugs themselves. Nevertheless, at this stage we must admit that the behavior changes caused by ataraxics cannot be reliably distinguished by standard tests in individual patients.

THE most important application of ataractic drugs is in anxiety reactions. In these conditions they may alter the subjective mood or psyche of patients, while objective changes may be entirely lacking. If these drugs are to be evaluated adequately, their subjective effects in patients must be measured and compared. Few clinical studies to date, however, have attempted to make adequate measurements of this kind on any of the ataractic drugs.

Technics for this purpose exist; they have been developed principally in the study of analgesics and hypnotics, which present similar problems in evaluation. All these technics rely on the fact that subjective estimates of effectiveness can yield reliable and reproducible results only if sources of bias and subconscious prejudice are eliminated. To accomplish this, it is necessary to compare two or more agents simultaneously; to assign patients to the different therapy groups at random—not haphazardly, but by methods that assure a random assignment; and to conduct the comparison in a "double-blind" fashion.

Distinctions between drugs can usually be made more powerful by comparing the effect of different agents on the same patients. This is called the "cross-over test." It is desirable to eliminate from the study group patients who react easily to suggestion. Such patients can be eliminated by the use of dummies or placebos that are indistinguishable from active compounds. Recent work[2] suggests that an inert placebo can be identified as such in many cases. For this reason an active substance should be used, the action of which mimics to some extent that of the drug being evaluated.

Few studies on ataractic drugs have used all these safeguards. This is to be expected in the preliminary clinical evaluation of new drugs, since the first studies must be directed toward demonstrating the existence of clinical efficacy rather than toward measuring its extent. Preliminary evaluations are equally concerned with the possible toxicity of the drugs being tested. The sophisticated technics I have mentioned are neither necessary nor desirable for this purpose.

NEVERTHELESS, a number of well-controlled studies have now been reported, primarily on the older compounds chlorpromazine and reserpine, but including a few on some of the newer agents. Let us compare the available ataractic agents with these studies in mind.

Ataraxics fall into several groups according to their chemical structure: the phenothiazine derivatives, the Rauwolfia alkaloids, the mephenesin-like compounds, and the diphenylmethane compounds.

The phenothiazine derivatives include chlorpromazine, promazine, proclorperazine, and mepazine. A number of alkaloids have been isolated from Rauwolfia extracts, but only two have had extensive clinical use: reserpine and rescinnamine. The only mephenesin-like compound to be used extensively as an ataraxic is meprobamate. The diphenylmethane group includes several of the newer ataraxics — hydroxyzine, benactyzine, and azacyclonol.

Controlled studies of many of these compounds have been conducted on both psychotic and neurotic patients.

In psychoses, chlorpromazine has been compared with placebo in several double-blind studies. Feldman's group [3] found that 9 of 11 patients improved on chlorpromazine while only 4 of 11 control patients improved on placebo. Fromm and Forsberg,[4] in a similar study, reported significant improvement in 8 of 12 patients on chlorpromazine, and in only one of 9 patients on placebo. Tenenbiatt and Spagno,[5] in a larger study, found 38 of 50 chronic psychotic patients improved on chlorpromazine, while only 4 of 50 patients in a paired control group improved on placebo. Zeller and his colleagues [6] found that 31 of 44 patients improved on chlorpromazine while only 14 of 51 patients improved on placebo.

Similar results have been obtained with reserpine in psychoses. Pearl and his colleagues [7] studied the effect of reserpine and placebo in 170 male schizophrenics, and found a significantly greater improvement on reserpine. Ware and Prout [8] found that 66 per cent of 50 patients improved on reserpine, while only 33 per cent showed improvement on placebo. Zeller's group [6] found that 23 of 37 patients improved on reserpine while only 13 of 44 improved on placebo.

Freeman and his colleagues,[9] using the "double-blind" technic, have determined the minimum dosage of chlorpromazine and reserpine necessary to produce effects significantly different from those of a placebo. Their figures, determined in hospitalized psychotics, are 800 milligrams of chlorpromazine a day, and 8 milligrams of reserpine a day.

Tucker and Wilensky [10] have just reported a double-blind study of meprobamate in chronic schizophrenia. They report improvement in 13 of 32 patients on meprobamate over a 12-week interval, but in only 3 of 31 patients on placebo.

Few attempts have been made to compare the effect of several drugs under similar conditions, with a view to ranking the agents. Rinaldi, Rudy, and Himwich [11] have made one such comparison using chlorpromazine, reserpine, and azacyclonol in psychotic patients under double-blind conditions. In a study on 40 patients, 32 of whom were schizophrenic, 32 improved on reserpine, 24 on chlorpromazine, and 21 on azacyclonol. They judged reserpine to be the most effective in hebephrenic states, and chlorpromazine most effective in paranoid states. Kovitz and his colleagues [12] found chlorpromazine consistently superior to reserpine in 25 chronic psychotics, both drugs being significantly better than placebos.

There have been several attempts to evaluate these compounds by criteria other than clinical impression. For instance, Feldman's group [3] compared the effect of chlorpromazine and placebo on ratings of psychotic patients on various standardized tests. Sommerness [13] has done a similar comparison with reserpine and placebo, as has Penman's group.[14] These attempts were unsuccessful, although a British study conducted by Wing [15] on 51 chronic psychotics distinguished a fairly well marked reserpine effect on the Fergus Falls Behavior Rating Test against a background of improvement on placebo. Swenson,[16] in a similar study on 100 patients in this country, also distinguished reserpine from placebo with statistically significant results.

It must be concluded that, at present, clinical judgment remains the most sensitive criterion of effectiveness in evaluating these drugs. When experiments are designed to combine the double-blind comparison technic with the exercise of careful judgment concerning the effects of therapy, very definite conclusions can be drawn about the value of ataractic drugs.

This type of clinical evaluation has proved satisfactory in establishing the value of ataraxics not only in the psychoses but in the psychoneuroses as well. However, the role of ataraxics in neurotic reactions is not yet as extensively documented as it is in the psychoses.

Preliminary reports on a number of new compounds indicate that several are of definite value in states of anxiety tension, but controlled studies have been completed in only a few instances to date.

The effectiveness of reserpine has been compared with that of placebo under double-blind conditions. Hollister[17] found that 13 of 20 patients with chronic anxiety reactions were benefited by a three-week course of reserpine, while only 6 were benefited by placebo. Meath and Feldberg[18] scored the symptoms of 14 similar patients on reserpine and on placebo. They found that the scores of their patients were better on reserpine than on placebo, although in this case (presumably because of the small number of patients) the difference did not prove significant. Their experiment was performed in such a way, however, that, although the scores for the whole group were not significant, the scores for two of the patients showed that they had benefited significantly from reserpine where the placebo had been ineffective.

Reserpine has been compared with phenobarbital by Hollister's group[17] in a double-blind investigation: 18 of 25 patients were benefited by reserpine over a three-week period, as compared with 6 who were benefited by phenobarbital.

THE effect of the new Rauwolfia alkaloid "rescinnamine" was determined by Hollister[17] in the same 20 patients who had taken reserpine. The proportion of patients benefiting was about the same in either case, but side reactions to rescinnamine were shown to be less severe. Although double-blind controls were not used in this test, Hollister felt that the conclusions in this case were reliable.

Meprobamate has also been subjected to double-blind studies in the psychoneuroses. West and da Fonseca[19] recently compared the effects of meprobamate and placebo in 26 patients selected by strict criteria. All had symptoms of anxiety and tension, and their symptoms had not varied appreciably for over a year. They found that meprobamate administered over a six-week interval gave results that were significantly better than those with placebo, under circumstances where there was less than a one per cent probability that the difference could be due to chance alone.

Benactyzine has also been reported effective in relieving symptoms of anxiety. In a double-blind study Raymond and Lucas[20] showed that benactyzine was more effective than placebo in 12 of 18 patients, while placebo was superior in only two.

Hydroxyzine, introduced in 1956 as Atarax®, has been compared with other tranquilizing agents and with placebos. In the treatment of senile anxiety states, for instance, Shalowitz[21] has found that the substitution of placebo for hydroxyzine regularly produced a recurrence of anxiety symptoms, and that hydroxyzine was equal or superior to chlorpromazine when the two drugs were compared in patients. Since hydroxyzine has shown a remarkable lack of undesirable side reactions, it appears to be a most useful compound in the therapy of "anxious" patients.

Studies such as these are the best kind of clinical evidence concerning the efficacy of ataractic drugs, and provide a good foundation for determining their everyday usefulness. At the same time, these studies reveal the difficulties inherent in evaluating their proper clinical use.

IN CERTAIN psychotic states characterized by gross behavior disturbances, the beneficial effect of several ataraxics has been demonstrated; moreover, clinical technics now in use seem to be generally adequate for the determination of their effects on behavior. However, it is still uncertain, on the basis of published reports, to what extent each drug is actually capable of restoring normal or acceptable behavior in different types of disorders.

The influence of these drugs on the subjective personality of patients is also uncertain. Here the difficulty seems to be that technics now in use are inadequate to demonstrate the total effect of many compounds. The problem is acute in the treatment of psychoneurotic anxiety states, where we know from controlled investigations that several compounds do indeed exert beneficial effects on "anxious" patients, but where we have no satisfactory way to analyze the extent of these effects under different circumstances.

One solution to this difficulty will be found

in the cooperative evaluation of ataractic agents by clinicians of several specialties. Specifically, I urge that the skills of psychiatry, psychology, and internal medicine be brought to bear jointly on the evaluation of ataractic therapy in anxiety states. Such cooperative endeavors have proved rewarding in related fields of medical investigation where technical advances required that new concepts and technics of therapy be developed. Cooperative clinical investigation of these new agents can result only in a still further improvement of therapy in many of the psychoneurotic disorders so commonly seen in clinical practice.

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A bibliography of 21 citations appears in Dr. Wright's reprints.

Discussion of Dr. Wright's Paper

Harrison F. English, M.D., Trenton: Although we know that social and personality problems are not solved by drug therapy, there is no doubt that the tranquilizing drugs are valuable contributions to the treatment of psychiatric patients. Anyone making ward rounds in a mental hospital will be struck by the relative silence that prevails in comparison with the noise and restlessness encountered on such rounds a few years ago. Of course, these drugs must be used judiciously. They are more effective in relieving anxiety and tension with much less danger of addiction than were the barbiturates which they have primarily replaced.

We are swamped by a wave of advertising literature with fantastic claims for new drugs being introduced faster than we can keep up with their names. The physician is used to this circus which is re-enacted every few years whenever a new group of drugs is introduced. He bases his estimate of their usefulness not upon the size of the brochure, but upon scientific trials of the drug concerned. Chlorpromazine and reserpine, although not without complications, are of proved worth, particularly in the treatment of psychotic patients. Meprobamate is of demonstrable value in the treatment of psychoneurotics. Many newer tranquilizing drugs are in the stage of having their worth tested. Marsilid®, a drug formerly used in tuberculosis, is showing promise in the treatment of certain depressed patients. A tremendous number of studies on the uses and effectiveness of these drugs is appearing each month in reputable medical journals. As Dr. Wright points out, these studies would be more useful if better criteria could be developed for determining the effectiveness of these drugs. Dr. Wright's paper is one of the better articles written on these drugs. In preparing this interesting monograph, Dr. Wright must have reviewed a vast amount of literature. As he says, the evaluation of the clinical usefulness of these drugs is beset by many pitfalls because of the difficulty of remaining objective in the evaluation of subjective sensations. However, he has pointed out to us a number of methods that, at least, partly overcome this difficulty.

Journal of Rheumatic Diseases

Announcement is made of the publication of a new medical periodical — *The Journal of Rheumatic Diseases*. Grune and Stratton will print the journal. It is sponsored by the American Rheumatism Association. Subscription is $8 to members of the Association and $10 to others. For subscriptions and details write to Dr. William D. Kimler of 127 Fourth Avenue, Haddon Heights, New Jersey.

V. Terrell Davis, M.D.

Trenton

New Principles in the Management of Mental Illness*

"The physician's role in the psychiatric ward" says Dr. Davis, "is becoming more of a medical role. His main function is seeing that there is careful and complete medical study." This and several other challenging ideas, highlight this presentation of new principles in psychiatric care.

It is obvious from even a casual glance at the newspaper, that the most important single area of man's interest in recent years is in the area of understanding and controlling anxiety. Our interest and study in this direction have been fruitful in terms of helping our understanding and management of mental illness. We no longer look upon anxiety as something abnormal, undesirable or even as something to be avoided. Rather, we recognize anxiety as the main driving force of human nature—up to a point, for we also know that extreme anxiety can be totally paralyzing and can actually precipitate a state of apathy.

Our goal is no longer an attempt to find an anxiety-free existence but rather to learn how to take anxiety in our stride and add to the vibrance of our life activities through the absorption and utilization of the potential of anxiety.

We have learned further that individuals react not only to their own anxieties but also to the anxieties of others in their environment. It is not necessary for anxiety to be verbalized to be communicated from one individual to another.

CONSTRUCTIVE HANDLING OF ANXIETY

Aiding the patient in dealing with his anxiety is the king pin in any therapeutic program. Even the severe symptoms of psychoneurosis and psychosis can be seen as methods which the human mind has developed for absorbing and handling excess amounts of anxiety. Clinical practice has repeatedly shown that as soon as the individual is able to handle his anxiety in more constructive channels there is a disappearance of the psychotic or neurotic symptoms. This applies to everyday activity as well. When we are more anxious our irritability and other obnoxious features show. In attempting to help the patient to deal with his anxieties it is necessary actually to identify the source of the anxieties and, even more important, to distinguish between the patient's anxieties and the anxieties which may have been concurrently aroused in the therapist or in significant individuals in the immediate environment. This is not easy.

*Read April 30, 1957 before the Psychiatry Section at the Annual Meeting of The Medical Society of New Jersey in Atlantic City. Dr. Davis is director of the Division of Mental Health, New Jersey State Department of Institutions and Agencies.

THE PHYSICIAN'S OWN ANXIETY

IT IS usually *our* anxieties which we attempt to alleviate by giving the patient false or empty reassurances, misleading information and by punitive and vindictive attitudes and arrogance toward the patient.

It is *our* anxiety which prompts us to talk about the patient behind his back instead of directly to him; which leads us to connive with a spouse or other relative about a course of indirect action; which interferes with our being forthright and frank with the patient with mental symptoms. It is our own irrational anxiety which prompts us to think in terms of prognosis before we have even begun to understand the diagnosis. Why should it be difficult to tell a patient that we do not know how serious his mental illness is and that therefore further study as an outpatient or inpatient is indicated? I'll always remember the first time I dealt frankly and directly with a seriously disturbed patient. The reaction of the patient was like that of a person lost in a foreign land who finds someone who can speak his language.

Our new principles in management of mental illness are basically the development of new methods of controlling the generation of anxiety, of removing the patient from anxiety-producing situations, of aiding the patient in handling his anxiety and finally in recognizing the iatrogenic factors in the total anxiety picture.

The tranquilizing drugs have for the first time given us a pharmaceutical product which has anxiety relieving features without being soporific or addicting. They fortunately do not lend themselves readily to complete relief of anxiety to the extent of apathy. However, in the hospital setting and in the doctor-patient relationship there is also a correlated positive factor. The hospital staff as well as the physician are reassured by having something positive and constructive to offer to the patient and thus do not reflect further anxiety to the patient's initial feeling of concern about his condition.

EARLY SHORT TERM HOSPITALIZATION

AT LEAST a hundred years ago it was recognized that a valuable function of a mental hospital was that it provided an environment which was conducive to recovery of mentally ill patients which could not be duplicated in the home environment even when money was no obstacle.[1] We are rediscovering today that early hospitalization under appropriate circumstances for a brief period may be the treatment of choice in many types of mental illnesses. What are these favorable circumstances?

1. Without legal entanglements.
2. Where a careful, complete medical study can be obtained.
3. Where he can be temporarily removed from the demands of everyday activity and its various decisions in order to have a chance, so to speak, to catch his breath.
4. In a facility which is familiar to the patient.
5. Where the staff is organized so that he will have an opportunity of having satisfying interpersonal relations with hospital personnel without loss of identity.
6. Where the patient will participate in a responsible manner in his rehabilitation program.
7. Where it is possible for him to continue to be seen by his private physician.
8. As close to the community of residence as possible.

The psychiatric unit in the general hospital most easily fulfills these needs. However, a closer integration with the community medical program is something which the hospitals specialized for psychiatry will have to achieve if we are going to use to the maximum effectiveness the knowledge which is currently available. State hospitals can no longer exist and function as isolated close-staffed organizations. We must more and more look to the practitioners in the vicinity of these institutions to furnish not only medical care but also psychiatric care and treatment on a visiting and part-time basis.

Inasmuch as inpatient hospital residence is only one cross-section of the longitudinal pic-

1. Kirkbride, Thomas S.: *Hospitals for the Insane*; Second Edition. 1880. Philadelphia. Lea and Company.

ture of the psychiatric illness, it is not possible for a psychiatrist to have a full and complete understanding of all the available knowledge about mental illness existing today if he sees only the same cross-section of the illness, as the result of a limited view from the psychiatric wards of a mental hospital. The psychiatrists in our State hospitals must see patients in the *early* stages of mental illness, either through general practice or through clinic affiliations. They must also have the opportunity of following the patients as they return to the community.

THE PHYSICIAN AND THE NURSE

Not so long ago we used to rate a psychiatric hospital by the intensity and competence of the psychotherapy by the physicians on the staff. Psychotherapy, we believe today, can most efficiently and effectively be carried out when the patient has reached the opportunity of outpatient treatment and is ready to assume at least a degree of responsibility for development of the treatment program. As a result, we see the physician's role in the psychiatric ward becoming more of a medical role in which the main function is seeing that there is careful and complete medical study and examination with proper utilization of medical and laboratory diagnostic skills and procedures. The psychiatric nurse is also important in the diagnostic procedure, as a result of the observations which she reports of the patient's activities, reactions and behavior patterns. In addition, the nurse is the key person in the structuring of the therapeutic hospital environment which, through its facilitation of more satisfactory interpersonal experiences on the part of the patient, provides the most significant therapy for the hospitalized patient.

CONCEPTS TO BE UNLEARNED

It is important that we put the record straight on several items which fall in the category of things which perhaps have been taken for granted without questioning for too long and as a result have served rather effectively as authoritative inhibitors of medical progress. There is no convincing clinical, anatomic, or neuropathologic evidence of the popular concept, "mental deterioration." The myth of the deterioration of personality in the epileptic has been exploded. The myth of personality deterioration as the result of the use of narcotic drugs has been exploded. There is no evidence of an actual deteriorative process *per se* in schizophrenia although we do see a pattern of deteriorative behavior. We have also seen that under seemingly favorable therapeutic situations this pattern of deterioration has been reversed.

Although self expression in some form is practically as essential as a continuation of breathing of air for human survival, the mere expression of hostility doesn't cure anything. There is a difference between expression of hostility and expression of a natural aggressive drive. The direct expression of hostility implies the hurting of another person and one of the significant things that any neurotic or psychotic needs to learn if he is to achieve a degree of recovery is that he cannot hurt another person without directly or indirectly, in one way or another, hurting himself. On the other hand, he can react to the hurt received in a constructively aggressive manner, and in a manner which will constructively prevent future similar hurts.

It has been a popular belief that we feel guilty today over something which we did weeks, months, or years ago. Actually, we feel guilty today over things which we are doing today in our everyday relationships with people but which we do not recognize because we have conveniently displaced our guilt feelings to vague objects in the past. An individual who goes around attempting to retaliate for all his imagined hurts from day to day may be the very person who likes to believe that his current dissatisfaction with himself arises out of something in the past.

ONE of the areas of most significant development of new concepts is in the medical-legal aspects of the practice of psychiatry. We are beginning to recognize the full degree of "responsibility" of which the patient is capable, and we are recognizing the need to distinguish between "commitability," being psychotic, and being "incompetent."

The next great break-through that we can expect will be in the clarification of our principles in the medical-legal area. We cannot open doors and treat patients in our mental hospital as people as long as they are admitted as disfranchised citizens. The physician-psychiatrist cannot perform his real function while allowing himself to be pushed into the role of judge, jury, prosecutor, defense, and jailor, all at the same time and all in relation to the same patient.

A hospital cannot perform its hospital functions when it is used as a "dumping ground" of the courts and when the court places emphasis on the secondary mental disability to the exclusion of any attention to the primary social problem which brought the individual to the attention of the court.

The break-through in these areas is not going to come as a result of any upheaval of our judicial and legal procedures, but rather it is going to come about as a result of more effective utilization of the knowledge and skills now available by physicians and through more discrimination in our judgments, observations, conclusions, and actions.

The physician, through his training and probably also because of the nature of his personality which originally motivated him to undertake the long hard road to the degree of Doctor of Medicine, has schooled himself against saying "I can't" or "I won't" when help is requested of him. We must be mindful of our own limitations, and yet have faith in the competence and integrity of the professionals in other fields.

Many of our problems in terms of admission to mental hospitals are the result of the perversion of commitment procedures, originally designed to protect the rights of the patient, to instruments to protect the staff from the overload of patients in inadequate hospital facilities. Why should a patient who seeks voluntary admission to a mental hospital have to fill out a ten-page questionnaire giving isolated information about family illnesses and personal history, copies of which go into the hospital record room, as well as to the county adjuster? The legal requirements are for an application form with information designed to establish place of residence and financial status if admission is requested without payment of the established *per diem*.

IT HAS not been the courts or the statutes which have given popular false acceptance of the idea that all mental patients are incompetent. It has been through the testimony of physicians and the confusion in our own thinking in these areas. We have failed to realize that insanity is a legal and not a medical term and that under the legal term certain conditions have to be met to qualify under the term "insanity." These conditions are not synonymous with medical diagnoses. Furthermore, even legally the condition of insanity is not synonymous with the "state of incompetence." There are separate legal procedures for the determination of insanity requiring hospitalization and for the determination of incompetence necessitating the appointment of a guardian. For practical reasons there are many individuals who have been committed as insane to mental institutions who are also incompetent, but no determination of this fact, or appointment of a guardian, has been made because there is no estate involved which would necessitate a responsible individual acting specifically for the patient.

Every physician must learn sooner or later that *psychoses are not under all circumstances conditions of insanity*. It is only when as the result of the psychoses that the individual requires institutional care for his protection or the protection of others that the conditions of insanity are met.

Further confusion has been added to the question by failure to recommend civil and criminal action against patients under treatment, either in the hospital or outside of the

hospital, for mental illnesses on the basis of the mistaken idea that the patient was not responsible. Responsibility must be a separate determination.

PROGRESS IN CHILD CARE

For too long everyone has considered himself an expert in understanding children, with the result that no one took sufficient time to study and understand the behavior of the mentally ill child and the problems of his therapeutic management. Children have a need for a firm, consistent, non-punitive discipline, with sufficient attempt to communicate and to provide opportunity for graduated successes. They need an environment which expects decent behavior but does not value itself above the individual. In a program of residential treatment for disturbed children it is only too easy for the staff to become more concerned about the damage to the buildings or equipment which results from an emotional blow-up, than to be concerned with the discomfort and turmoil which the child was experiencing which prompted the emotional blow-up. If we are to be therapeutically oriented and save the wear and tear on the buildings in the long run, we must be more interested in understanding the child and helping him to constructive behavior than in being concerned about the damage which has already happened.

It is necessary to help the child to develop tolerance for the human frailties of his parents, a pride in the good which is in the worst of parents, and to learn that satisfaction that was not found within the particular home situation can be found in relations with others.

In dealing with parents of teenagers we have found that it is particularly important that the parents be given assistance in meeting the challenges of being the parents of an adolescent. They don't need to be criticized because of their failures; they are only too keenly aware of them.

Parents have their biggest problems when their children are adolescents. Things move so fast through adolescence that it is impossible for us to blaze a trail over which we can direct our children. We and our children, therefore, have to rely on our faith in the good judgment of our children to shoot this set of rapids in the stream of life with the minimum of bruises. However, whatever the cost in terms of bruises or damage, the trip must be made, because to remain comfortably above the rapids is to miss life.

HOPE FOR THE AGED

For centuries the poets have spoken of the elderly individuals in terms of a "second childhood." Many of the patients being admitted to our mental hospitals today are older individuals whose seemingly child-like behavior is taken as an indication of advancing mental deterioration due to old age. We have discovered that the prognosis for these individuals is extremely brighter than we had ever imagined and that the basic principle underlying rehabilitation is the principle of combatting the individual's helplessness.

Some of the most dramatic results have been obtained in the intensive rehabilitative treatment of patients, even older than 80, who have suffered from cerebro-vascular accidents with partial paralysis and incontinence. The helplessness and disgust which the patient (as well as the ward worker) experiences on finding himself in a wet bed are the most serious problems and must be approached at once with devices for ambulating the patient sufficiently to use toilet facilities frequently enough to control his incontinence.

We have learned to plan for the discharge of even the oldest of patients at the time they are admitted, just as we have learned to plan for the discharge of even the sickest of the disturbed children at the time of their admission to the institution.

However, it is quite frequent with the older patient that there have been factors within the home or family situation which have made it impossible for the older individual to find means of combatting his feelings of helplessness and dependence, and under these circumstances we have looked to our family care

programs to provide a satisfying and productive living experience for these individuals in the community.

SUMMARY

We have seen that patients, whether children or aged, act like people. Their reactions can pretty well be predicted if we know how they are being treated. Our own anxieties have contributed to our failure to be more discerning in our clinical observations, more discriminating in our judgments, and more understanding in our treatment. We have no reason to feel guilty over the past but we must change our ways now.

135 West Hanover Street

Emotional Maladjustment May Block Rehabilitation

Anxiety can complicate the hope for rehabilitation in the physically disabled. So writes Gillette* who reports that he adds meprobamate to his physical therapy program. He estimates that this aids 80 per cent of the patients. Thus, he describes a 7-year old girl who had, since birth suffered from severe athetosis, a type of cerebral palsy. Tension was so great that the child was unable to talk. Meprobamate was added to physical therapy and within six months the child was able to speak.

A nine-year old boy suffering from spastic paralysis of all four extremities with tremor and contractions, showed a marked improvement when meprobamate was added to treatment.

"After three months meprobamate was added," Dr. Gillette reported * "with gratifying results in lessening of spasticity and complete cessation of tremor. It was possible to begin academic instruction shortly after medication with meprobamate was included in the treatment."

Meprobamate not only tranquilizes the emotions, but also exerts a direct physical relaxant action. Thus, in the muscle in spasm, tension and rigidity are released and tonus is lessened to an extent over and beyond the effect produced by mere reduction of emotional stress. In patients suffering from skeletomuscular disorders, the addition of meprobamate to the treatment helped every patient. In 40 per cent of the patients, pain, spasm and emotional tension were relieved and range of motion was made near normal. With the reduction of tension and alleviation of pain, pain-relieving and sleep-inducing drugs were less frequently required.

"In addition to lessening of the emotional tension, there was an actual relaxation of the contracted muscles so that they yielded more readily to stretching and manipulation," Dr. Gillette said.* "In most cases patients cooperated more willingly in carrying out the exercise program. Progress was more rapid and physical therapy could be terminated earlier."

Patients with cerebral palsy exhibited a "very definite" reduction of tension and within three days there was a perceptible relaxation of muscles and reduction of flailing motions so that braces could be applied more easily.

In many patients the lessening of emotional tension and relaxation of the muscles meant that "walking was accomplished with less difficulty and increased endurance; spastic upper extremities became less helpless . . . speech became more intelligible . . . there was a distinct improvement in disposition . . . children who had wakened often at night . . . slept soundly . . ."

In general, patients suffering acute muscle spasms responded best to the drug. No patient developed a tolerance to the drug. Rarely was it necessary to increase the dose to support the initial results. Drowsiness, the major side effect of the medication, was controlled by reducing the dosage.

*Dr. Gillette's report appears in the July 1956 International Record of Medicine.

A. M. Sabety, M.D.

East Orange

Pectus Excavatum*

Pectus excavatum or funnel chest is a congenital anomaly in which the body of the sternum is depressed. Correction and fixation are indicated to remove the emotional impact of this gross deformity, to prevent or correct cardio-pulmonary deficiency, and to correct a defect in chest contour.

Pectus excavatum is a congenital anomaly in which the body of the sternum is depressed to form a concavity. This may reach the vertebral bodies or, passing to one side, into the paravertebral gutter. The lower costal cartilages on either side bend back toward the dorsally displaced sternum, giving breadth to the concavity, the depth of which is usually maximal just above the xyphi-sternal junction.

The point of maximum depression is usually over the lower sternum. Sometimes, however, the deformity is more diffuse and the thoracic cage is flattened anterio-posteriorly. Between these two extremes, one may find a variety of different shapes that the bony thorax may take.

These are by no means the only abnormalities present. Other structures are also affected. Cervical and dorsal spine and ribs show pronounced changes. The thoracic viscera also show both anatomic and physiologic changes. In far advanced anterior chest wall abnormality, it seems the whole body framework is affected. These patients are more or less round-shouldered in appearance, and tend to be tall and slender. The head and neck usually project downward, while there is a dorsal kyphosis and scoliosis. The chest is narrow, elongated and flat. The ribs join the spine at an acute angle and are more than ordinarily oblique, giving the characteristic chest x-ray findings. The heart is usually displaced to the left, the abdomen is protuberant. The liver is ptotic and breathing is noticeably abnormal.

While this developmental condition has been known for years, its surgical correction is relatively recent. The condition is usually recognized from birth. Occasionally the deformity may be missed even by a competent observer, until the infant is several weeks or months old.

A certain number of these patients have cardio-respiratory complaints. Whether the dyspnea is primarily pulmonary or cardiac in origin is not definitely known. It is conceivable that such a great displacement of the mediastinal organs to one side or the other (as seen in these cases) does interfere with proper cardiac filling and emptying by distortion of the great vessels. This may explain the hyposthenic appearance of some of these children. Electrocardiograms may show axis deviation, and an inversion of the T wave. Certain cardiologists insist that the deformity is not responsible for the cardiac symptoms. Evans at the London Hospital maintained such a view. This theory, however, is hard to understand considering the marked displacement of the heart, its rotation and torsion, and, the

*Read May 1, 1957 before the Chest Diseases Section of The Medical Society of New Jersey.

fact that considerable numbers of patients have been relieved of their cardiac symptoms by correction of the deformity.

Inversion of the T wave in the right precordial leads, should not be mistaken for a sign of coronary insufficiency. Reading electrocardiograms without knowledge of the chest configuration of the patient may lead to erroneous interpretation.

Symptoms referrable to the pulmonary system are those of compression of the lung, decreased vital capacity, occasional bronchiectasis more pronounced on the left lower lobe.

ETIOLOGY

FUNNEL chest occurs in about 1 to 16,000 of the general population, in ratio of one female to 4 males. In females the deformity may be pronounced before puberty. Cosmetically, it is not as striking after the full development of the breasts, and universal methods of concealment by means of a bras. For these reasons, the emotional impact is not as great as in the male patient.

Various causes have been suggested. These include:

1. Abnormal or deficient development of the sternum and costal cartilages.
2. Respiratory obstruction, as from enlarged tonsils and adenoids.
3. Nutritional deficiencies.
4. Congenital shortening of the central portion of the diaphragm, which is intimately connected to the xyphoid cartilage.
5. Faulty development of the musculo-sternal portion of the diaphragm causing the xyphoid to be drawn in during inspiration.

TREATMENT

TREATMENT of funnel chest is surgical. The type of operation depends upon the age of the patient and the extent of the deformity. In infants, one year or younger, a simple freeing of the sternum from the diaphragmatic pull is expected to give good proportion of satisfactory results. A limited operation of the Brown type should be attempted in infants with severe deformity. Many of these children may require a secondary operation at a later date. If there is a progression of the deformity, and there is no symptom, the ideal time for correction seems to be between the ages of 3 and 5. Beyond this age, skeletal changes are such that radical operations do not give the same cosmetically good result. Most of these operations are based on the principle of maintaining sternal elevation and correcting the deformed costal cartilages. The technic varies only in the manner by which these two aims are reached. Our present method is subperi-chondral removal of all deformed cartilages; transverse wedge osteotomy of the anterior cortex of the sternum at the level of the manubrio-gladiolar junction and, maintenance of the sternum in its new location by the reapproximation of the wedge osteotomy and the use of a rib graft.

OUR survey is based on 14 cases. Ten have been operated on so far. In these ten cases there was no operative mortality. Clinically, there was no wound infection, osteomyelitis or chondritis. One patient developed postoperative atelectasis and pneumonitis in the left lower lobe, which was subsequently shown to be a bronchiectatic lobe. Except for the first two cases no traction wires or outside splints were used. In the two cases with outside splints, the wires used for traction ruptured spontaneously on the 7th and 11th postoperative day respectively. No attempt was made to replace the wires. The cosmetic result was excellent in 8 cases. Nine of the 10 showed a return of the heart to its normal position. One patient, at the age of 30, sought surgical correction of the deformity for psychologic reasons.

Keloid formation in the surgical scar occurred in 6 cases. In only one was it quite extensive. This one received x-ray treatment and some improvement was noticed in the keloid. Keloid formation is interesting in these cases and is postulated to be secondary to excessive fibro-plastic disorder.

SUMMARY

Our experience in the treatment of pectus excavatum based on 14 cases is reported. We have come to the conclusion that correction of this deformity is indicated for the following reasons:

1. To correct sternal deformity.
2. To prevent or partly correct the anterio-posterior flattening of the entire chest.
3. To prevent cardio-pulmonary insufficiency in later life.
4. To correct cardio-pulmonary deficiency, if present.
5. To remove the great emotional impact of funnel chest on an affected child.

Our technic is based on Brown's original work†: correction and fixation of the deformed sternum and costal cartilages. An illustrative case is presented.

†Brown, A. Lincoln: Funnel Chest (Pectus Excavatum) in Infancy and Adult Life. Arnold and Company. London, 1947.

144 South Harrison Street

Hydrocortisone Ointments Need Prescription

On January 20, 1956, the Food and Drug Administration exempted from the prescription requirement, various salves and lotions containing hydrocortisone. The companies interested in wider sale of such salves and lotions argued that:

1. Hydrocortisone and hydrocortisone acetate are *not* absorbed through the human skin when ointments and lotions containing the drugs are applied to the skin.

2. No systemic effects of hydrocortisone have been observed clinically in the course of extensive use under medical supervision of ointments and lotions containing hydrocortisone and hydrocortisone acetate.

3. Hydrocortisone and hydrocortisone acetate ointments and lotions have been used extensively under medical supervision, without reports of any significant adverse reactions.

4. Such preparations are effective and useful in the treatment or alleviation of many minor skin irritations.

A year later, however, FDA reversed itself. On the basis of testimony by dermatologists, pharmacologists and some manufacturing pharmacists the FDA concluded that the drugs were not safe for indiscriminate non-prescription use, and restored these preparations to the roster of drugs requiring a prescription. The reasons given were:

1. Studies by newly devised laboratory procedures showed absorption of hydrocortisone and hydrocortisone acetate through the skin and through mucous membranes adjoining skin areas, following application to such areas of ointments and lotions containing the drugs.

2. There are documented cases of serious adverse effects following application of hydrocortisone preparations to the skin under medical supervision, particularly cases in which such preparations caused the spread of infection, the presence of which was undetected by the attending physician.

3. In general, laymen cannot differentiate between skin conditions in which ointments or lotions of hydrocortisone or hydrocortisone acetate are indicated and those in which such preparations are contraindicated.

4. Qualified experts believe it impossible to write adequate directions for use of hydrocortisone or hydrocortisone acetate ointments and lotions in self-medication.

5. Since hydrocortisone and hydrocortisone acetate ointments and lotions relieve temporarily but do not cure the conditions in which they are indicated, a layman would use the drugs beyond the time limit stated in the labeling to obtain continued relief of symptoms. Prolonged use of that kind would increase the hazard of systemic effects from absorption.

"In view of the above, the Commissioner of Food and Drugs cannot conclude that the drugs are safe for use as provided in the proposed regulation. It is concluded that the prescription-dispensing requirements of hydrocortisone and hydrocortisone acetate are necessary for the protection of the public health. Accordingly, the petitions to exempt hydrocortisone and hydrocortisone acetate ointments and lotions from prescription-dispensing requirements are denied."

PETER MARVEL, M.D.

Northfield

The Medical Challenge of the Twentieth Century*

It is the fashion to tease about obesity and make fun of diet control. But, as Dr. Marvel here points out, it is no laughing matter. Cardiovascular disease, the number 1 killer in America, can be reduced if weight is reduced. This is the 20th century challenge to the medical profession.

WE DOCTORS of medicine are dedicated to the prevention and relief of human suffering and disease and to the prolongation of healthful living. We are now living through an era of the greatest accomplishments in all history of medicine. Current medical advances have revolutionized the practice of medicine and have placed in the hands of physicians four priceless keys to better health for our patients.

The first key was fashioned by Louis Pasteur when he proved the existence of bacteria as a cause of disease. This gave us a starting point for the development of chemotherapeutic agents, prophylactic immunization, and the ever growing list of antibiotics. These agents have enabled us to reduce the death rate from 1900 to 1956:

(A) Pneumonia, bronchitis and influenza by 90 per cent
(B) Tuberculosis by 94 per cent
(C) Infectious diarrhea and other gastro-intestinal diseases by 96 per cent
(D) Diphtheria and smallpox by 99 per cent

The second key was fashioned by the Dutch Nobel Prize winner, Dr. C. Eijkman, when he advanced the theory that certain diseases were caused by the "absence of something" then unknown and unseen. Biochemists later identified Eijkman's unknown substance as "vitamins" and demonstrated their vital role. Vitamins have made possible an entirely new approach to prophylactic and therapeutic medicine. True deficiency diseases are now medical curiosities. Vitamins have augmented our therapeutic inventory in practically every medical specialty.

The third key was forged in the field of endocrinology. Knowledge of the physiology and pathology of the glands of internal secretion has revolutionized our thinking and our therapy. Pancreatic, thyroid, and sex gland dysfunctions are now rationally treated by hormone replacement therapy. Kendall's compound E opened the door to many new concepts and applications related to the rapidly growing list of the steroid hormones of the adrenal glands.

This knowledge unlocked the inner chambers of newer disease concepts. It fostered the stress and adaptation theory of Hans Selye, with its multiple ramifications into the physiology and pathologic physiology of practically every organ system of the body.

The fourth key of progress was developed

*Read by invitation before the general staff of the Shore Memorial Hospital, Feb. 17, 1957, at Somers Point, N. J.

in surgery—notably in thoracic, vascular, pediatric and neurologic surgery. In addition to new and improved technics the tremendous salvage of life and relief of suffering accomplished by modern surgeons has been made possible by:

(1) Developments in the field of anesthesia
(2) Antibiotic control of infection
(3) Application of knowledge in the control of electrolytes, fluids and blood replacement, *et cetera*, embodied in the terms pre- and postoperative care.

The fifth key is now in the door. As yet, it has failed to unlock the secrets of the two leading causes of death: cardiovascular disease and cancer.

From a practical point of view as clinicians we must accept the meager knowledge of and therapy for cancer from two very inadequate approaches as our only therapeutic weapons; (1) early detection, (2) early surgery and/or radiation to eliminate the discovered lesions.

An ever rising death rate, particularly from coronary and cerebral vascular disease (that strikes hardest at our middle-aged, productive male population) has been a source of great concern in medical, public health and government circles. Our own profession heads the list in comparative vocations. If for no other than a selfish reason we should be even more concerned. In the last 25 years, mortality from heart disease in the United States has risen from 4.6 to 8.6. This has occurred in spite of a 70 per cent drop in deaths from valvular and endocardial disease. Over 50,000 middle-aged Americans die each year from coronary disease. The rate increases annually.

Life insurance companies have statistics that uncontestably show a relationship of excess body weight to morbidity and mortality rates. One-fifth of our adult population over thirty years of age is sufficiently overweight to pose a real health hazard. Any condition which affects one out of every five adults would seem to merit sincere attention. Overweight people suffer:

51 per cent more from cardiac disease
65 per cent more from vascular disease
250 per cent more from diabetes
200 per cent greater hazard in surgery
67 per cent more from cirrhosis
72 per cent more from nephritis
18 per cent more from appendicitis

Even the incidence of accidents and suicides is increased in obesity. Within certain limits, a decrease in life expectancy may be correlated with the degree of obesity. Thirty to fifty pounds overweight means 50 per cent higher death rate at any age compared to the rate for people of normal weight. Adult males in the United States with cardiac disease who are 20 per cent overweight, have a 50 per cent increased mortality compared to the general population.

We clinicians must fully appreciate this information in our approach to preventive medicine in general and to the problem of cardiovascular and other degenerative disease in particular. This evidence is so convincing and we have at our command such practical weapons, that I believe this problem justifies the title of this presentation: "The Medical Challenge of the Twentieth Century."

The need for control measures against any public health problem can be evaluated in the light of three factors:

(1) The extent of the problem
(2) The hazards to health and life
(3) The practicality of control measures

The extent of the problem and its hazards can be appreciated by the data reported above. The practicality of control measures is receiving wide attention.

In 1955 a National Weight Control Conference was held at The Iowa State College. Participants included leaders in the fields of medicine, genetics, biochemistry, physiology, nutrition, psychology, sociology, education, home economics and public health. Publication of the papers presented at the conference are filed in the Congressional Library, catalogue No. 55-9961. Although much controversial material is presented in this document, it is abundantly clear that obesity and the composition

of the American diet are realistic medical problems.

Dietary fat is not the sole cause of coronary disease. Yet we cannot overlook the implied relationships. Many studies, especially the one by Keys,[1] confirm this. Keys[1] reviewed cholesterol-lipoprotein blood studies in many countries, the percentage of dietary fats and incidence of coronary disease. Studies in Spain, Sweden, Africa, Italy and the United States show a striking relationship between the diets in these countries and the serum lipoprotein cholesterol values. Likewise he reported a remarkable parallel between these studies and the incidence of coronary heart disease in those populations.

His survey shows that the United States and England have the highest incidence of coronary disease. These countries also have the highest dietary fat content, 40 per cent and 35 per cent respectively, compared to a 20 per cent dietary fat content in countries with the lowest incidence of coronary disease; *e. g.,* Japan and Italy. There has been a trend towards a higher proportion of fats in the American diet (by 10 per cent in the past 30 years). The United States Army military diet has a 45 per cent fat calorie content.

In Finland and Norway where reliable health statistics have been maintained, a marked reduction in the dietary fat occurred during World War II. Accompanying this decrease in fat consumption a sharp drop in mortality from coronary disease occurred in less than two years. Where the fat curtailment was less pronounced or less prolonged, as in Sweden and The Netherlands, coronary disease showed a less dramatic decrease. In countries where the other impacts of war were similar, but the diet fat unaffected as in Denmark, the incidence of coronary heart disease did not change. When dietary fat resumed its pre-war level in those deprived countries, the incidence of coronary heart disease returned to its former level.

For centuries, Yemenite Jews were accustomed to a low fat diet. They enjoyed relative freedom from coronary heart disease. Since 1946, after migration into Israel with the diet changing toward the richer fat pattern of European Jews, serum cholesterol values rose; and there was an increased incidence of coronary heart disease.

In Japan and among the Bantu natives of South Africa, whose diets are extremely low in fat content, the age-by-age incidence of degenerative diseases is only a small fraction of our own. With improved economic conditions of the Bantu native there was an increase in his dietary fat. This was accompanied by a corresponding rise in serum cholesterol and subsequent increase in coronary disease.

Autopsy statistics on American soldiers who died in the Korean conflict startled us by the finding of atherosclerosis in the blood vessels of our so-called healthy young adults. These soldiers were Americans who grew up between the wars. These young Americans enjoyed all the advantages of "proper" nutrition which we as doctors have been stressing for 25 years.

All these facts, observations and statistics cannot be ignored. We have all observed patients with diabetes whose disease can be controlled without insulin simply by reducing their weight. An obese patient on insulin can frequently have his insulin requirements reduced or eliminated just by lowering his weight. We have been impressed by the number of hypertensives whose blood pressure can be substantially lowered solely by weight control. Obese cardiacs in failure are immensely helped and their lives substantially prolonged by reducing excess poundage. The morale boost that the overweight menopausal female gets by losing ugly fat pads and regaining an attractive figure has multiple ramifications in her health and family life. The obese male or female patient who has excessive sweating, breathlessness with minor exertion, and difficulty in walking, aside from his or her physical unattractiveness, is a much happier and healthier person if we can help him lose excess weight.

Leanness leads to longevity. Obesity increases morbidity and mortality. As doctors,

can we accept lightly so serious a problem that affects so many of us?

The pathogenesis of atherosclerosis is being intensively studied since it is accepted as the basic pathologic disorder in most cardiovascular degenerative diseases. The mechanisms are not wholly understood but it is probable that atheromatous formation is encouraged by body fat storage. A relationship of body fat and dietary fat is incriminated. Atherosclerosis is an acquired metabolic disease that may be prevented and is by no means always non-reversible. It is characterized by abnormal amounts, or an abnormal physical state (or both) of the cholesterol-containing aggregates in the blood plasma. Since the systemic factor determines whether any atherosclerotic lesions will form, the disease is potentially controllable by alteration of the blood lipids. Moreover, serum lipids and cholesterol are in direct proportion to dietary fat intake. Therefore, I contend that this is largely a remedial problem.

THERE are many unproved theories about the etiology of obesity. One basic concept, however, is irrefutable. Barring gross endocrine abnormality, which is relatively rare, *obesity results from a disproportion of caloric intake and energy output.* If we eat more than we need, we store it. The person who is gaining weight and storing fat is in disequilibrium. His food intake is not in balance with his body requirements. In adult obesity, weight gain is 99 per cent fat storage. There is minimal muscle, bone or visceral change after maturity and prior to involution and senescence. Many factors of course influence body caloric requirements: physical exercise, emotional energy expenditures, age, hereditary body conformation, vocation, climatic influences and body metabolism. However, homeostatic mechanisms of the body tend to match the food intake to the body needs. By our eating habits, we distort this mechanism of homeostasis if we become overweight. Psychiatric management of emotional factors which are occasionally causally related to unrestrained, or compulsive eating may prove necessary.

I think it is necessary and urgent to approach this ever growing and serious problem from two aspects:

(1) Our concept of nutrition must be drastically changed from the pediatric stage up. What about the food charts that hang on the walls in most hospital clinics, baby stations and public schools? These stress the healthful qualities of butter, ice cream, chocolate, grade A milk and milk desserts. Is it any wonder that our twenty-year old soldiers have atherosclerosis when we raise them on such high fat diets? Most of us were reared with emphasis on these foods plus the enjoyment of lush desserts and soda fountain delicacies. It is understandable how the American diet has increased from 30 per cent fat calories to 45 per cent, the highest in the world. This is "Civilization's dietary contribution to death"! We are all victims of habit. The pattern of eating is a habit established in childhood which must be changed. We must try to establish "The Optimal Diet for Optimal Health Throughout an Optimal Span of Life."

The time to prevent obesity is in childhood. The time to check it, once developed, is in the third decade in men or the fourth decade in women, *i.e.*, before serious pathologic changes have occurred.

(2) On the management of the obese adult, I would like to make a few comments. We doctors must recognize the implications of the issue and educate the public on the serious hazards of obesity, especially in mid-life.

We must stress the need of modifying our eating habits as a vital public health issue.

We must take seriously the overweight patients who consult us and realize the vital role we play in controlling the mortality and morbidity of these people. This statistically is far more important than the much heralded cancer control programs. The obese patient must be convinced, by our attitude and approach, of the wisdom of reducing. Successfully to follow out a weight control program, he must truly want to reduce. He must, through us, learn that he can reduce only by lowering his caloric intake below his body requirements until he reaches his goal. The problem then becomes one of maintaining

homeostatic balance. Body fat comes from food and from nothing else. You do not have to be gluttonous to get fat (though one often is); but you have to eat more than your maintenance requirements in order to gain weight.

MANY obese patients are emotionally unstable and seek panaceas for their problem. Fad diets and advertised "easy reducing plans" are like the pot of gold at the end of the rainbow. Patients trying for an easy "out" never find it. Proper orientation and encouragement, periodic supervision plus the judicious use of anorectic, sedative, and hypermetabolic drugs will be useful adjuncts in producing results.

Decreasing caloric intake does not call for drastic starvation diets. Simple elimination of salad oils, all fried foods, desserts other than fruits, and the complete avoidance of between-meal and bed time snacks, will result in an appreciable decreased caloric intake. Patients must become food and calorie conscious. In the early weeks of management, strict mathematical control usually pays off. A prescribed diet of 1000 to 1500 calories with simple specific calorie food charts for substitution, low in fat, maximum in bulky carbohydrates and adequate in protein is usually best. It is my policy to vary medications for maximum therapeutic as well as psychologic effects. Two week periodic office visits are optimal to record weight, blood pressure, general evaluation, orientation and ventilation. Prescriptions are interchanged each visit from T.I.D., anorectic, bulk, and sedative medication of different dosages and combinations with occasional delayed action type of obesity medication. Although not agreed by all, after an interval of caloric restriction and weight loss, hypometabolism ensues. This can be periodically boosted by one or two weeks of substitution thyroid extract, which further enriches the therapeutic equipment.

Body weight can be controlled by caloric restriction and the distribution of obesity can be modified by exercise. This does not imply violent calesthenics or athletics. People should be encouraged to walk rather than ride to nearby places. The average adult expends about 100 calories in walking one mile. The typical housewife and office worker walks an average of five miles per day. The farmer who once walked behind a plow using 400 calories per hour, now rides his tractor using 130 calories per hour. The housewife who used to wash clothes and scrub floor at 250 calories per hour now uses modern housekeeping equipment at 120 calories per hour. Sitting by the television restricts energy output that used to be expended in recreational hobbies requiring much more exercise. Patients can be oriented around these facts and encouraged to double their activities to great advantage. Calesthenics and more rigorous exercise can be specifically prescribed when muscle tone and physical conditions indicate and sensibly permit. Paul Dudley White advocates "sensible" physical exercise as heart disease prophylaxis. With this belief I heartily concur. The platter and lazy twentieth century luxury living are undermining our civilization. Elbow bending, our popular pastime, is inadequate exercise to promote good health.

IN THE interests of forty million obese Americans we must accept this twentieth century medical challenge and help salvage them from inevitable premature death or disease. As doctors we have within our grasp the know-how and obligation to meet this challenge. This will prevent more illness than our prophylactic immunization campaign against contagious diseases of childhood. Yes, proper weight control of our midlife Americans will save more lives than all the surgeons' scalpels throughout the land.

The simple act of boiling milk, water and bottles was the biggest contribution to reducing infant mortality that only a few years ago was third on the list as a cause of death in America. Diet revisions and obesity control will prove to be our greatest contribution toward stemming the tide of the rising incidence of degenerative disease—the number one killer in America.

SUMMARY

Obesity influences morbidity and mortality. As clinicians we must appreciate this relationship, particularly as applied to cardiovascular diseases. Obesity results solely from disproportion of calorie intake and energy output. There is much evidence to incriminate blood lipids and cholesterol in the production of atherosclerosis, the basic pathologic disorder. Atherosclerosis may be prevented. It is by no means always non-reversible. Our concepts of nutrition must be altered from the pediatric stage up. The high fat content of the American diet might well be labeled "Civilization's Dietary Contribution to Death." Obesity control is a real medical challenge. A suggested plan of therapy is outlined.

2216 Shore Road

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Rib Cartilage Used to Produce Ear

Diced cartilage from ribs, nurtured in a mold buried in the abdominal wall, is being used successfully in the construction of missing ears, said our Dr. Peer to the 1956 International College of Surgeons. This work done on children before school age "facilitated adjustment with playmates and prevented a feeling of being different."

Dr. Peer told the Congress that he had devised cartilage grafts 15 years ago for the repair of skull depressions and later applied such material to the construction of ears in persons born without ears or who had lost an ear because of an accident.

Satisfactory results were obtained in 80 per cent. Most of the failures occurred in the early operations, with satisfactory results in nine out of 10 cases in the last year. Dr. Peer explained that best results were obtained when cartilage was taken from the patient's ribs. Use also was made of preserved bank cartilage alone or in combination with that from the patient's body. The cartilage is cut into many fine pieces "much as a cook dices carrots in preparing a salad." The diced grafts are put into a perforated vitallium ear mold and the two halves of the mold fastened together, pressing the cartilage segments into the form of an ear. The mold with its contents is introduced into a pocket formed beneath the patient's abdominal skin and a pressure dressing applied to keep the mold firmly in place.

The mold remains in place for about five months. During this time the patient's tissues grow through the openings in the mold and fasten the separate diced cartilage segments together in the form of an ear. Thus, when the mold is removed from the patient's tissue and the two halves separated a cartilage ear framework has been formed by nature's own process of healing.

This cartilage framework is then inserted in a pocket in the region of the absent ear and the skin pressed firmly against the framework which produces a flat ear in the region where no ear was present. Later, the framework is separated from the side of the head and the back portion covered with a skin graft taken from the patient's abdominal wall.

"This permits the new ear to stand out at an angle which matches the normal ear on the opposite side of the head."

Dr. Peer said that in children he preferred to start the reconstruction when the child is 3½ years old. Thus, the ear is completed when the child is five years of age which enables it to enter school without a marked physical handicap.

A. Russell Sherman, M.D.

Newark

Percentage Evaluation of Visual Disability*

In our increasingly insurance-covered culture the doctor has the duty of developing objective criteria for evaluating disability. In ophthalmology this is not done simply by refraction. There is more to it than that—as evidenced by this useful article by Dr. Sherman.

In 1923 the Eye, Ear, Nose and Throat Section of The Medical Society of New Jersey recommended, and the House of Delegates adopted a schedule which[1] is still used by the New Jersey Department of Labor as a basis for awarding compensation for visual impairment caused by industrial injuries. The schedule is a table of percentage equivalents of Snellen expressions, plus methods of evaluating disturbance in muscle function and visual field. When there is impairment in more than one of these functions, one multiplies together the percentage efficiency of each, thus: V. A. (visual acuity) times V. F. (visual field) times M. F. (muscle function). If, for example, in a traumatic muscle palsy (with normal central visual acuity and normal peripheral field), there is a 40 per cent loss of function of one eye, the percentage of visual efficiency of this eye would be 1.00 (V.A.) times 1.00 (V.F.) times 0.60 (M.F.). If, in addition, there is a loss of the visual field of 25 per cent, the formula would be 1.00 (V.A.) times 0.75 (V.F.) times 0.60 (M.F.). If there is still further impairment in the form of loss of central acuity of 20 per cent, the formula would be 0.80 (V.A.) times 0.75 (V.F.) times 0.60 (M.F.). This determines the visual efficiency of the eye, and this percentage subtracted from 100 gives, of course, the visual impairment. The desirability of a suitable waiting period before computation of permanent disability is also emphasized.

The Snellen expression is confusing because it is commonly thought of as a fraction, and for this reason it was the intention of the committee that the ophthalmologist should use this schedule in computing percentage disability, and report the disability in terms of percentages alone. However, the referees and deputy directors who preside at hearings have familiarized themselves with the table of Snellen values and percentage equivalents, and make their independent calculations, usually with complete satisfaction (mathematically at least), since only a small number of claimants have an impairment other than that related to loss of central visual acuity.

In 1925 the House of Delegates[2] of the American Medical Association adopted a resolution endorsing the report to its Section on Ophthalmology, including an item on compensation for eye injuries. It was hoped that this report, the culmination of ten years' work, would serve throughout the country as a basis

*Read on May 1, 1957 before the Ophthalmology Section of The Medical Society of New Jersey at the Atlantic City Annual Meeting.

1. Sherman, E. S.: Journal of The Medical Society of New Jersey, 20:389 (Nov.) 1923.

2. American Medical Association: 1925 Transactions of Ophthalmology Section, p. 368.

for the appraisal of loss of visual efficiency. At this same meeting, A. C. Snell[3] and Edward Jackson[4] presented papers on allied subjects.

Snell[3] reported an analysis of 100 selected cases with defective vision, particularly with respect to the effect of lowered visual acuity on the individual's ability to work, and on his earning capacity. In this report he states, "It is so generally conceded that a visual acuity better than 20/40 Snellen and less than 20/20 Snellen has little or no effect on visual efficiency, that only those cases with acuity of not better than 20/40 Snellen are included in the tabulation. However, I have made a study of several hundred industrial employees with visual acuity of 20/25 or 20/33 Snellen in the better eye, and in no instance, no matter how fine or delicate the work might be, did I find that these trivial defects ultimately influenced either the efficiency of the worker or his earning capacity." He finds,[3] "A perusal of these tabulated cases will reveal that no patient had any loss either to his working or to his earning ability until visual acuity fell at least to 20/65 Snellen in the better eye." In commenting on his findings, Snell[3] calls attention to the obvious asset of familiarity with the work in cases of defective sight; also, he points out that repeated injuries, each of a trivial nature, may have an accumulated effect on earning power. This latter fact would seem to justify and demand the detecting, reporting and compensating of individuals with these small defects.

In the 1925 A.M.A. report, the same three elements as in our 1923 report are recognized as contributing to full visual efficiency: (1) visual acuity, (2) visual field, (3) muscle function. A table is presented for conversion from Snellen expressions to percentages. The values are somewhat different from those in the New Jersey report. The extent from the fixation point of the normal or maximum visual field in each of the eight principal meridians is specified, and the method for converting findings into percentage values is given, as well as a method of determining efficiency of muscle function.

The questions of correcting glasses, near *versus* distance visual acuity, and the presence of pre-existing subnormal vision are discussed. A formula for expressing the industrial visual efficiency of the individual in terms of total permanent disability is recommended.

1941 A.M.A. REPORT

IN 1941 a revised report[5] was presented to the Section on Ophthalmology of the A.M.A. by the Committee on Visual Economics.

The table of percentage loss of visual efficiency corresponding to Snellen notations is left unchanged. A new value for the normal field of vision, approximately ten degrees greater in each meridian, and a simpler though less scientific method of determining muscle function efficiency are presented. No statute has been changed in accord with the 1925 recommendation that awards be based on the percentage of permanent disability. This recommendation is therefore omitted.

1955 A.M.A. REPORT

A FURTHER revision[6] was recommended by a committee and accepted by the Section on Ophthalmology of the A.M.A. in June, 1955. This specifies that in determining central visual acuity, a Snellen block letter or number chart without serifs, the illiterate **E**, or Landolt's broken-ring chart is desirable. The sizes of the letters in the test lines form a geometric progression in which each line is 26 per cent larger than the next smaller one, or 20 per cent smaller than the next larger.

The percentage values given for various degrees of loss of central visual acuity for distance differ slightly from those of the earlier report. The percentage table is only half as long, and progresses conveniently in steps of

3. Snell, A. C.: Page 227 of the report cited as 2 above.

4. Jackson, Edward: Page 319 of the report cited as 2 above.

5. American Medical Association: 1941 Transactions of Ophthalmology Section. p. 329.

6. American Medical Association: 1955 Transactions of Ophthalmology Section. p. 249.

five per cent or ten per cent. Certain ambiguous and confusing (to the lay person, at least) statements have been omitted.

APHAKIA

AN EXCELLENT discussion of the problem of aphakia in an otherwise well-functioning eye is included,[6] and it is recommended that monocular aphakia be classed as a loss of 50 per cent; *e.g.* if, with correction, the vision of the aphakic eye is 100 per cent, the visual loss is 50 per cent; if there is 30 per cent impairment (70 per cent efficiency) of the aphakic eye with correction, there is 0.70 times 0.50 = 35 per cent efficiency (65 per cent loss). A decision of the Court of Errors and Appeals of New Jersey[7] would seem to prevent the application of this principle in this state.

VISUAL FIELD

THE maximum or normal visual field retains its same value (the sum of the eight meridians is 500 degrees), but in the case of a concentric contraction to five degrees in every meridian the loss is 92 per cent, a change which is mathematically more exact, but for our purposes of only academic interest. A glaring error in which only three meridians (3/8) were considered for loss of half the field, and one meridian (1/8) for loss of one-quarter the field, has been corrected; so that in the case of loss of the nasal field for example, one considers the upper nasal, the nasal, the lower nasal and an average of the upper and lower meridians.

DISTURBANCES OF MOTILITY

A DIFFERENT method of determining the percentage disability resulting from disturbances of motility is presented. It is assumed that diplopia beyond 30 degrees of fixation does not cause disability except on looking downward. The presence of diplopia is determined, therefore, at 10 degrees, 20 degrees, and 30 degrees in each of the three upper and at 10 degrees, 20 degrees, 30 degrees and 40 degrees in each of the other 45 degree meridians, using a small light without colored lenses or correcting prisms.

Diplopia within the central 20 degrees is considered 100 per cent loss. More peripheral diplopia is a partial loss as shown in figure 1.

It is suggested that loss of binocular single vision without other ocular abnormality be considered 50 per cent loss.

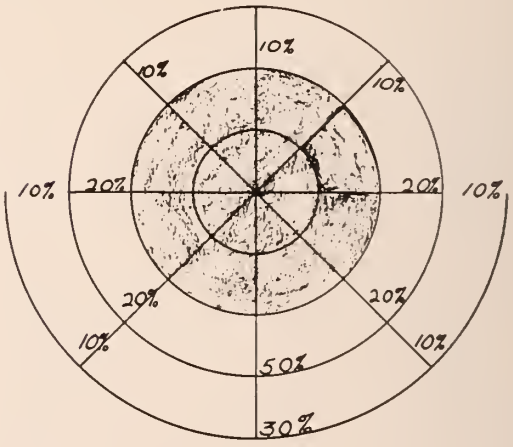


Figure 1.

Ptosis is not mentioned in this 1955 A.M.A. report,[6] but there is a simple method which I have used of estimating the loss resulting from ptosis. The patient is examined with a small light and with a base in prism before one or both eyes sufficient to cause horizontal diplopia. The area in which diplopia does not occur is a measure of the loss of motor field efficiency. The test can very conveniently be performed with the patient sitting before a tangent screen marked off into 20 squares (as recommended for determining motor field efficiency in the A.M.A. reports of 1925 and 1941), and each of the 20 squares represents 5 per cent (figure 2).

7. Johannsen v Union Iron Works: 97 N. J. Law 569. Decision dated June 23, 1922.

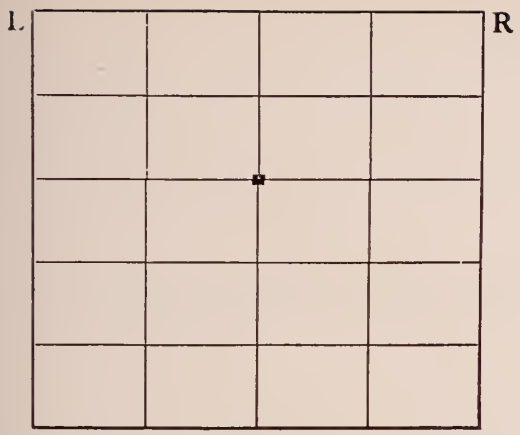


Figure 2.

DISTURBANCE OF NEAR VISION

IT HAS been my experience that, except in the case of the most honest and perceptive patient, a test of near vision is likely to be less accurate and satisfactory than of distant vision. One who wishes to test near vision will find a revised table of percentage loss for near vision in the report. Instead of having the near values correspond with the distance ones (20/40=14/28, 20/100=14/70), a diminished percentage value is given to the visual acuities of 14/28 or better, and in increased value to those of poorer than 14/28. It is recommended that an average be taken of the central visual acuity for distance and for near.

Any test of the vision is purely subjective and in making such tests one cannot afford to ignore the remarks of Dr. Jackson[4] concerning such examinations: "It may be felt that, vision being subjective, no one but the individual himself can tell whether or not he is blind. It is equally true that the individual must generally know better than anyone else whether he has committed a murder or theft, or planned and assisted in any crime, or really is justly entitled to some piece of property he has claimed. But as in any of those cases, the interest of the claimant in his alleged blindness often renders his testimony worthless. If his testimony is admitted, it gains significance and weight only as it is corroborated by collateral evidence over which the claimant's self interest has no vitiating influence. To elicit, weigh and present such unbiased evidence, and to estimate its value; in other words, to bring out and estimate the value of objective evidence of blindness is the business of the ophthalmologist."

605 Broad Street

Speech Training of Deaf Mute

Totally deaf persons without speech can learn to work and associate in normal society and become successful business people and home makers. So said Dr. Ralph M. Stuck of Denver to the International College of Surgeons at its 1956 Congress.

This can be accomplished by speech training which combines the sensations of sight, hearing and touch pressure and motion with an emotional adjustment.

"A patient's whole nature may be, and usually is, affected by the character of his speech," he said. "The effect is particularly adverse if he has a speech defect. The totally deaf person without speech is likely to be discouraged, despondent or antagonistic. His psychologic problems often overwhelm him to the extent that he is unable to adjust to normal society and he tries to limit his association to those similarly afflicted. He is afraid of the competition of normal persons. To most such subjects, speech has been denied not because the capacity to speak is lacking, but because it is only recently that methods have been developed to teach the deaf to speak. In children, the problem is frequently a parent-child psychologic block with antagonism and resentment, but it may also be a reaction to frustration in another sphere.

PHOEBE HUDSON, M.D.

Westwood

Premature Mortality in a Community Hospital

Small, but good, community hospitals, like the Hackensack Hospital, do as well in preserving premature babies as many of the larger, university-affiliated, elaborately equipped institutions. The most challenging finding here, however, is that premature babies weighing between 1000 and 1500 Grams do better in the larger "premature centers."

PREMATURE survival studies published since the advent of the isolette, use of oxygen and water mist, have been from large Premature Centers where the admissions are high and facilities are, theoretically, the best. Figures from small hospitals are not presented for several reasons. They are not teaching institutions, do not have financial resources, and have a less homogenous program. However, it is of interest to know the rates from such hospitals so that those of similar size as well as large, more extensively equipped institutions, can compare results. Figures have been collected from Hackensack (N.J.) Hospital for the 6-year period ending December 31, 1955.

In a hospital of this type, the babies are delivered by both general practitioners and obstetricians. Babies in the premature nursery are under the care of pediatricians, obstetricians, and general practitioners with over-all supervision by the Pediatric Department. It is the policy of the hospital to remove such babies as quickly as possible to the premature nursery.

As far as can be ascertained all babies born alive and below five pounds in weight are included in this series.

TABLE 1. RESULTS

Year	Alive	Dead	Total	Per Cent Dead
1950	70	35	105	33-1/3
1951	49	25	74	33-1/3
1952	48	16	64	25
1953	42	25	67	37½
1954	62	24	86	28
1955	61	26	87	30

Total survivors through the six years—332. Grand total was 483 babies. Average mortality was 31 per cent.

Table 2 shows the breakdown by sex and color. The mortality rate for Negro children was 49 per cent, while it was only 32½ per cent for white babies. However, the series included only 48 Negro infants out of 483. With this small incidence of Negro children it would be inaccurate to draw any statistical conclusions from the difference in mortality. It will be noted that our group also included 5 "Jackson whites." This refers to a group of people indigenous to northern Bergen County and southern Rockland County (New York) of mixed Indian-Negro-white ancestry, supposed to have descended from Revolutionary War unions of Hessian soldiers with Indian or Negro Americans.

TABLE 2. SEX AND COLOR

Total		Live	Dead	Mortality Per Cent
426	White	298	128	32
5	Jackson white	2	3	60
48	Negro	28	20	49
4	Color not stated	4	0	0
483	Grand total	332	151	31
248	Females, all races	189	59	24
234	Males, all races	142	92	40
1	Sex not stated	1	0	0
483	Grand total	332	151	31

Male infants had a mortality rate of 40 per cent and females of 24 per cent. This difference in favor of female survival has been reported before. It seems to be at the borderline of statistical significance.

Table 3 relates mortality to intrauterine life. In this table "months" designates lunar months. The longer the intrauterine life, the lower the mortality, the ratio of death being 15 per cent in the "32 plus weeks" group, rising to 96 per cent in the "under 24 weeks" group.

TABLE 3. INTRAUTERINE LIFE

Total		Live	Dead	Per Cent Mortality
26	Less than 6 months (24 wks.)	1	25	96
105	6 to 7 months (24-28 wks.)	45	60	59
141	7 to 8 months (28-32 wks.)	109	32	23
143	More than 8 months (32 plus wks.)	122	21	15
68	Not given	55	13	19

TABLE 4. CONDITION AT BIRTH

	Total	Live	Dead	Mortality
Good	308	286	22	7%
Fair	67	34	33	49%
Poor	91	9	82	90%
Critical (moribund)	15	1	14	83%
Not given	2	2	0	0

In the entire group there were not more than 2 or 3 mid-forceps deliveries. Note the 50 per cent mortality in the "section" group.

TABLE 5. TYPE OF DELIVERY

Total		Live	Dead	Mortality
334	Spontaneous, low, or mid forceps	250	84	34%
84	Breech	54	30	38%
40	Cesarean section	20	20	50%
1	Shoulder	0	1	100%
8	Unreported	7	1	13%

TABLE 6. AGE AT DEATH

Less than 1 hour	15 or 10%
1 hour to 6 hours	44 or 29%
6 hours to 24 hours	55 or 37%
24 hours to 48 hours	11 or 7%
Over 48 hours	24 or 16%
Not given	2 or 1%

Only 26 of 151 babies survived more than 48 hours.

Autopsies were done on 22 of the babies. Atelectasis was found in 14. Two babies showed tentorial tears and hemorrhage. One case each was found of: amniotic fluid aspiration; pulmonary congestion; petechial hemorrhage in heart or lungs; and adrenal hemorrhage. In 5 cases the pathologist's conclusion was simply "prematurity." This dearth of significant autopsy findings is characteristic of studies of the subject.

Antibiotics were, for the most part, used for minor causes. In the entire group of dead babies only three or four (in retrospect) seemed to have died of infection.

TABLE 7. WEIGHT ON DISCHARGE

Pounds	
3 to 4	2
4 to 5	8
5 to 6	297
6 to 7	21
7 to 9	0
9 to 10	1
Not given	3

Five pounds is the usual discharge weight in the larger centers. Apparently, babies are kept in small hospitals until they reach a higher weight. Our "weight" policy is, in turn, re-

flected in the "stay in hospital" figures shown in table 8.

Of the 483 babies, 101 were twins — that is more than 20 per cent of these premature infants were twins. One set of babies here, in fact, were triplets. Our 483 babies represented 433 confinements and 50 multiple births; one of the latter accounted for the triplets, and there were 49 pairs of twins. Thus, 50/433 or 12 per cent of our confinements were multiple births. The national average is less than 2 per cent. Thus multiple pregnancies were 6 times as common in this premature group as in a normal group of term deliveries.

TABLE 8. LENGTH OF HOSPITALIZATION

Days	
Less than 10	6
10 to 25	137
25 to 35	103
35 to 50	52
50 to 75	26
75 to 100	6
More than 100	2

Ten of the 151 deceased babies had congenital anomalies. The list included 5 with club feet and 3 with supernumerary fingers. Represented by one instance each were: anencephalos, extra toe, syndactyly, congenitally short leg, meningocele, ovarian cyst, thoracic spina bifida, hare lip and cleft palate. Among the babies who survived were 3 with hypospadias, 2 with hemangiomata and one each with hydrocephalos, coarctation of the aorta, hydrocele, mongolism, cerebral aplasia, massive unilateral atelectasis, patent intraventricular defect, ruptured mycotics aneurism, and club foot, in addition to at least one obvious mental retardation and one possible cystic fibrosis of the pancreas.

As a basis for comparison, examine table 9 which shows figures graciously furnished by the New York City Health Department. It reflects the prematures born in that city's "premature centers" in 1955. Babies brought to the centers by ambulance are not included.

The most challenging figure in table 9 is that on the "1000 to 1500 Grams" line where

TABLE 9. NEW YORK CITY AND HACKENSACK FIGURES

New York City			Hackensack Hospital	
	%		6-Yr.	1955
Total	Mortality	Weight in Grams	Period	Only
372	94	Less than 1000	95	92
367	44	1000 to 1500	59	67
679	14	1500 to 2000 Grams	13	7
2366	3	Over 2 kilograms	*	*

*Babies weighing over 5 pounds are excluded from the "premature" classification in the Hackensack Hospital series. Five pounds equal 2170 Grams.

we had a 67 per cent mortality in 1955 compared with a 44 per cent rate in New York. Actually, Hackensack Hospital compares favorably with many fine New York institutions on an individual basis. For example, in the "Under 1000 Grams" group, we had a premature fatality rate of 92 per cent in 1955. In that year, higher rates were reported for this group by Queens General Hospital (96 per cent), Bellevue (100 per cent), New York Babies' Hospital (100 per cent) and Lincoln Hospital (100 per cent). In the 1000 to 1500 Gram group, our 1955 rate was 66.7 per cent, and here every reporting New York City Hospital was better. For the 6-year study period, however, our fatality incidence in this weight group was only 58½ per cent compared with 63 per cent at the New York Hospital and 61.8 per cent at Bellevue. In the "1500 to 2000 Gram" group, Hackensack's 1955 rate was 6.9 per cent, and in this respect we had a lower mortality rate than any New York hospital in the reporting group. Their death rates in the 1500 to 2000 Gram group, for 1955 were:

Hackensack	6.9	Queens	16.6
Lincoln	7.8	Babies' Hospital	20.0
Kings County	8.5	Mt. Sinai	23.7
Harlem	8.8	Bellevue	24.2
N. Y. Hospital	11.9	St. Vincent's	28.6

CONCLUSIONS

It would be rash to draw firm conclusions from these variegated figures. However, the following points are certainly worthy of mention:

1. The figures from our small hospital correlate well with those from large, university-affiliated institutions.
2. Weight at birth and condition at birth are the most important factors in survival. Early deaths (82 per cent within 48 hours) exclude many possibilities of assisting the baby. These two factors, weight and condition at birth, remain the most reliable prognostic aids.
3. Type of delivery did not seem to be of importance.
4. The value of antibiotics is not revealed in this study although I feel that their use at minimum evidence of infection is warranted.
5. Congenital anomalies as shown in these figures, do not play a prominent nor significant part in cause of death.
6. Autopsy findings are peculiarly unrevealing.
7. The superiority for survival of white females over white males is evident.
8. The high rate of twinning in premature groups is once again emphasized.
9. This review raises some doubt about the ultimate value of all the equipment, technics and care given to premature infants. Actually, I had hoped to be able to conclude (or at least show evidence) in the opposite direction. I am unable to do so. Our premature service is a single, well equipped room lacking only in the more elaborate facilities, nursing care, and space allotment of larger centers. From this review I cannot say that any very drastic changes are in order.
10. In our circumstances the most challenging problem is the weight group 1,000 to 1,500 Grams, where a possibly viable baby could respond to the methods available.

10 Fairview Avenue

Music at Meals?

If restaurant owners are right, you may be your stomach's worst enemy. We doctors agree that indigestion and gastric distress come from eating while tense and anxious. Yet 93.7 per cent of the restaurateurs in a recent study reported that their customers are already suffering from "nervous tension" when they come in to eat. This is based on a cross-section survey of 4,000 restaurant owners.

The great danger from tension is that it may destroy appetite. So food experts have a strong interest in keeping you relaxed.

Restaurant men say that meal time tension causes diner behavior that harms customers, waiters, and profits. Tension-related customer problems reported by restaurateurs in the survey were, in order of importance: impatience and irritability waiting for service, cited by 50 per cent; complaints about service, by 35 per cent; excessive smoking, 33 per cent; excess coffee drinking, 30 per cent; and dissatisfaction with meals, 28 per cent.

The food experts have definite ideas about how to stop the meal time tension which drives diners to drink and dissatisfaction. In addition to friendly service, they stress the importance of pleasant, comfortable surroundings. For such an environment 52 per cent of the restaurateurs called for air conditioning, 36 per cent specified background music, and 12 per cent suggested factors such as soundproofing, indirect lighting, and cleanliness.

Air conditioning only cools in summer and maintains an even temperature all year. It eliminates food odors, smoke and stale air. Background music rests people and stimulates digestion. It does this by affecting the thalamus, it changes breathing, pulse, blood pressure, and metabolism as well as appetite.

Restaurant owners realize that music affects digestion. In fact, 69 per cent of the restaurateurs polled in a recent survey by *American Restaurant Magazine* used music in dining areas. Furthermore, 88 per cent of these said specifically they used music as a means of satisfying customers.

Rieva Rosh, M.D.
New York

Oscar H. Cohen, M.D.
Boonton

Nicholas G. Demy, M.D.
Plainfield

Walter Lentino, M.D.
Succasunna

Modern Treatment of Breast Cancer*

A fatalistic attitude towards metastatic breast carcinoma is deplored. A vigorous treatment program is presented, but its results are not reported.

Cancer of the breast is the most common malignancy in the female. It is responsible for 20,000 deaths annually in the United States. Over 90 per cent of the cases fall into the inoperable category, because of extension of the disease, distant metastases, or recurrence following radical mastectomy. The latter comprises the vast majority of patients with carcinoma of the breast. Their care is an important problem. The philosophy too frequently presented by many physicians is that they should go somewhere to die quietly since their fate is biologically predetermined by the type of tumor they have. When the terminal stages ensue, narcotics will be the only recourse. Their concept, all too frequently accepted by the family, is that if surgery fails then the patient is doomed.

It is to dispel this erroneous concept that this presentation is made. It is based on 30 years of experience in the care of people coming to the Radiation Therapy Department of Bellevue Hospital.

Therapy for carcinoma of the breast has undergone considerable changes through the years. Radium is still used in selected cases. Radioactive gold has come into use in combating malignant pleural effusions and ascites. Steroids play an active role in controlling the hormonal balance. External radiation still continues as the major modality. The kindly individual care of the patient has remained unchanged and is of the utmost importance. The system that has evolved at Bellevue Hospital we feel is a good one and we describe it to serve as a reference for other Tumor Centers.

*Read by invitation before the Congress of Radiology at Mexico City, July 4, 1956. This work is from the Radiation Therapy Department at Bellevue Hospital, New York.

The Radiation Therapy Breast Clinic

The general principles under which the Breast Tumor clinic functions in the Radiation Therapy Department of Bellevue Hospital are the following:

All modalities (radium, x-ray, steroids and radio-isotopes) are under the direct control of the radiotherapist. In many hospitals, the steroids are under the supervision of the internist, endocrinologist or gynecologist; the

radio-isotopes under control of the internist and x-ray alone is supervised by the radiotherapist. This does not best serve the interests of the patient. When different specialists control separate modalities, there is a tendency for the patient to be treated according to the specialist's training rather than treating the all-over picture of the patient's needs. One therapist in control of all modalities, with consultations as and when required, is in the best position to prescribe suitable therapy using one modality alone or in combination. An example would be a patient with recurrent chest wall carcinoma and malignant pleural effusion, where the isotopist would favor first using radioactive gold and might overlook the fact that external radiation could treat the overlying chest wall lesion and affect the pleural effusion at the same time. Considerable difficulty and confusion could be avoided by the single therapist preventing the referral back and forth of patients and also avoiding a tendency of "buck-passing." The patient would also benefit considerably in time and energy by having only one therapist who could take care of the major complaints and complications that might arise.

It may be asked why all the modalities should be controlled by the radiation therapist rather than by the surgeon or internist. The reasons are:

1. Radiation therapy training cannot be acquired in a short period of time. It is a full fledged specialty by itself.
2. The radiation therapist is best equipped to acquire the knowledge of radio-isotopes because of his basic training in radiation physics.
3. The use of steroids is now fairly standard, knowledge of these readily acquired and the changes observed closely parallel the changes already observed by the radiotherapist who used castration by x-radiation prior to the introduction of steroids.

Every patient with cancer of the breast attending our clinic is assigned to one attending radiotherapist and one resident in radiation therapy. The therapist follows the patient regularly with the resident observing and noting the changes in each patient. In most busy clinics the patient is taught to regard all the physicians equally. In the process, he loses the physician-patient relationship which is vital to the best practice of medicine. The emotional boost given to the patient in knowing that she has a resident physician in constant daily attendance when needed as well as one competent attending physician supervising all of the details of her case is an extremely necessary part of the care of the cancer patient. The importance of regular interval follow-ups at least once weekly in addition to the daily observations by the resident are the important features of our program.

Careful regular observations as to the regression of the tumor, the healing of ulcerations and the radiation reaction of the skin are essential to the proper management of the patient. Psychologically the patient is benefitted. The patient is made to feel that her disease is being actively and hopefully combated. She appreciates the keen interest taken by all concerned. Her complaints are listened to sympathetically and appropriate remedies prescribed promptly.

The patient is treated as a whole with all the medical problems adjusted and cared for. Patients with cancer of the breast "get married, have children, listen to the radio and television and eat apple pie." They are typical of the middle-aged woman and are liable to all the other diseases that women of this age group may develop. They have dental problems, develop hypertension, get gall bladder disease and feel tired. All of these problems should be promptly attended to wherever possible and not ignored just because they have mammary cancer and seem "hopeless." Anything that benefits the general health of the patient will prolong her longevity. Consultations with the family physician or other specialists are always in order.

The exact technical methods employed in the radiation therapy department are difficult to spell out since deviations are frequently required in the clinical management of the individual patient. The following is only a rough outline:

1. Palliative radiation for bony metastases.
2. Palliative radiation for local recurrences in the skin.

3. Steroid therapy for bony and soft tissue involvement.
4. Roentgen castration (premenopausal) if no surgery is indicated.
5. Radioactive gold is used for malignant pleural effusions or ascites.
6. Postoperative radiation is applied to lymph node drainage areas.

PALLIATIVE THERAPY FOR BONY METASTASES

AVERAGE dose administered is 2000r in two weeks. It is usually given through a single directly overlying portal. If the patient has multiple metastases, symptomatic areas are treated to a point of relief from 1000r in one week to 3000r in three weeks.

LOCAL RECURRENCES

LOCALIZED zones of skin involvement are treated with superficial therapy using 100KV (no filter) and 1500r are given 3 times a week for one week. This usually effects a local "cure."

STEROIDS

THE role of androgens, estrogens and to a lesser extent cortisone in clinical practice has now been fairly well established. The following dosage schedules are used in our radiation therapy department:

1. Androgen-testosterone proprionate—100 milligrams three times a week for 3 or 4 months.
2. Estrogen-diethylstilbesterol — 5 milligrams three times a day for 3 or 4 months.
3. Adrenal-cortisone — 200 to 300 milligrams per day.

The indications for therapy with steroids are loosely followed using the pattern below:

a. Up to 5 years: postmenopausal-androgens.
b. After 10 years: postmenopausal-estrogens.
c. Between 5 and 10 years postmenopausal we may switch from androgens to estrogens if no clinical response is noted. It is stated that bone lesions are best treated with androgens and soft tissue lesions with estrogens. However, we have found that the age of the patient and relation to the menopause are a more reliable guide to therapy with steroids. Clinical observations and laboratory studies are necessary in using steroids to avoid disturbing side effects. Hirsutism, acne, enlargement of the clitoris, increased libido, weight gain and deepening of the voice are seen with the androgens as well as occasional hypercalcemia. Interval bleeding, hot flushes, urinary incontinence, abdominal cramps with nausea and vomiting and fluid balance disturbances may occur with estrogens. Occasionally an estrogenic dependent carcinoma may flare up under estrogen therapy. Cortisone is used in recalcitrant cases and is still experimental.

The beneficial effects from steroid therapy are subjective and objective. Euphoria is common. Relief of bone pain is often noted and soft tissue nodules regress. Bone lesions may show recalcification of previous osteolytic processes.

ROENTGEN CASTRATION

STERILIZATION may be accomplished either by surgery or radiation. When radiation is elected for this purpose, certain factors determine proper roentgen dosage. Regularity of the periods is important. Women who are irregular are easier to sterilize. The obese patient is harder to sterilize due to the increased depth of the ovaries from the skin surface. The younger patients are also more difficult to sterilize. A depth dose of 1200r accomplished through two anterior and two posterior pelvic portals 10 by 15 centimeters in size over a 2½ week period is the average dosage used—modified by the factors described above.

RADIO-ISOTOPES

RADIOACTIVE isotopes have limited but useful effect in the control of pleural effusions and ascites due to metastatic spread from carcinoma of the breast. Colloidal gold 198 is a widely accepted agent of choice. Recent work suggests that it may be superseded by radioactive yttrium which is a pure beta emitter

and has a half life of 61 hours. This would considerably reduce the radiation hazard. Radioactive colloidal chromic phosphate has also been used for the same purpose. Our experience has been limited to the use of radiogold. Diluted gold in doses of about 100 millicuries for pleural effusions and 150 millicuries for peritoneal fluid are the average amounts employed. Results are not statistically spectacular but about half of the patients are benefitted in diminished necessity for repeat tapping of the affected cavities. Nitrogen mustard although not radioactive has also been instilled in the pleural cavity for malignant fluid.

*Dr. Demy.

LYMPH NODE THERAPY

STAGE I carcinoma of the breast (proved by radical mastectomy to have no axillary nodal spread) is not treated by radiation therapy. As Portman, Paterson and Cade have pointed out, therapy is contra-indicated since it prejudices the future use of therapy in the event of recurrences. Stage II carcinoma of the breast proved to have nodes receive extensive radiation therapy using a method outlined by one of us.* In this technic, the breast itself is not irradiated because it is assumed that the surgery has been adequate for the local lesion. The radiation is directed to the axillary, supraclavicular and mediastinal nodes.

115 Church Street, Boonton (Dr. Cohen)

Postoperative Radiation

Dr. Harper* discusses the advantages of using radiation sources after operation rather than during operation. Owing to the nature of these sources, their application at operation must be hurried. When a deep-seated lesion can be approached and isolated in a leisurely manner, the application of radiation is more effective.

A very fine polyethylene tube is threaded into the region to be irradiated. Organs not to be irradiated can be removed from the danger zone (*e.g.* intestine). The radio-isotope desired can be aspirated through the tube after operation. The precise dose can be calculated and the therapist adequately protected.

Short-lived radio-isotopes can be inserted and left *in situ* without need for removal. Such isotopes as radio-active yttrium can be used to prevent seeding of cancer; for example, Y90 can be placed in the peritoneal cavity after removal of an intestinal cancer, and it will be taken up by any tumor cell that may have spilled at operation. This has been proved by seeding cancer cells in the peritoneal cavities of experimental animals and subsequently introducing a solution of Y90. Radioautographs show that Y90 is taken up by the tumor.

*Dr Paul Harper of the University of Chicago testified in June 1956 before the Atomic Energy Committee of Congress. This abstract of his testimony was prepared by Dr. Paul Kolisch of Phillipsburg, New Jersey.

Silent Rupture of the Uterus*

Neither of the two cases here reported presented the classical signs or symptoms of uterine rupture. Each patient experienced a normal labor, an atraumatic delivery, and a normal postpartum course. Neither patient complained of pain following delivery, nor did either show any sign of intra-abdominal hemorrhage.

The diagnosis of uterine rupture under these circumstances cannot be made except by laparotomy. These cases are presented as a possible explanation for a classical rupture of the uterus in subsequent pregnancies. It is impossible to estimate how often such an asymptomatic, partial rupture of the uterus may occur. Routine intrauterine exploration will not confirm this type of rupture, as in both cases the tear involved only the peritoneal covering and the muscle of the uterus, with an intact endometrium. This type of rupture cannot be classified under the usual terminology. According to Stander: "It is customary to distinguish between complete and incomplete rupture, according as the laceration communicates directly with the abdominal cavity, or is separated from it by the peritoneal covering of the uterus or the broad ligament."

*Mendel, E. B. and Bone, F. W.: American Journal of Obstetrics and Gynecology, 71:1122 (May 1956)

R. D. Harley, M.D.

Atlantic City

Some Psychosomatic Aspects of Primary Glaucoma*

Emotions affect intra-ocular vascular tension and hypothalamic functioning. It is, therefore, not surprising to learn that emotions may play a role in precipitating glaucomatous attacks. Dr. Harley finds encouraging results with the use of reserpine and chlorpromazine in the treatment of emotionally precipitated glaucoma.

Proof of the relationship between elevated ocular tension and emotions is difficult to obtain with our present knowledge and technics. However, clinical experience has demonstrated repeatedly that some significant relationship exists.

Glaucoma seems to be the result of a combination of two factors: (1) the obstruction to the outflow of the intra-ocular fluid and (2) a disturbance of the intra-ocular and general circulation in close relationship with the nervous control of these mechanisms. The weight of present scientific evidence [11] favors the first factor.

This paper will present some clinical evidence which suggests that emotional disturbances may be an important causal factor in some cases of glaucoma. This, in turn, suggests an improved therapeutic approach to this disease.

The emotional and excitable temperament of glaucomatous subjects has been recognized for over half a century by such observers as Demours, Von Graefe, Donders and De Wecker. Undoubtedly, Plato had this in mind when he said, "For this is the great error of our day: that physicians separate the soul from the body."

Alexander [1] has divided psychosomatic manifestations into fundamental psychologic and physiological entities. Hysterical conversion symptoms are exemplified by blepharospasm, asthenopia and photophobia. Glaucoma, migraine and central angiospastic retinopathy illustrate disorders which can probably be attributed to neurovegetative dysfunction.

Ever since Adamuk's experiments indicating a preliminary rise in the intra-ocular tension on stimulation of the sympathetic nerve and Jonnesco's advocacy of the treatment of glaucoma by sympathectomy, a hyperexcitability of the sympathetic nervous system has been stressed as a characteristic of the glaucomatous patient. The connection between the sympathetic nervous system and glaucoma has been emphasized by Bailliart, A. Knapp, La. Grange, Smith, Barkan and many others.[2]

Disturbances of the autonomic nerves in glaucoma are suggested by the following observations:

a. General vaso-motor instability (capillary dilatation).

b. Tendency to development of angioneurotic type of edema.

c. Ready dilatation of the pupil with epinephrine.

d. Frequent response of the hypertensive state to the vaso-stimulatory action of epinephrine.

e. The association of acute attacks of glaucoma with the menses and emotional disturbances such

*Read before the Fifth Pan-American Congress of Ophthalmology in Santiago, Chile, Jan. 1956. This work is from the Department of Ophthalmology, Temple University, School of Medicine, Philadelphia.

as exhaustion and strain, anxiety, overwork, insomnia, insecurity and the shock which accompanies tragedy, financial loss, domestic discord and extramarital irregularities.

Duke-Elder summarizes these statements by noting that patients suffering from glaucoma are as a rule unstable in their neurovegetative reactions. It is an absence of the normal balance between the sympathetic and para-sympathetic systems. Hartman[15] studied glaucoma patients and found them almost uniformly poorly adjusted to their environment and suffering from constant anxiety, prolonged tension, insecurity and fear. He cites individuals in occupied France under war conditions. Many authors (Inman, Schoenberg, Seidel, E. Jackson, Lewis, Barkan and Harrington)[3] have illustrated the role of the psyche in precipitation of a single attack of acute congestive glaucoma. Almost every ophthalmologist can duplicate these case histories from his own records.

The following abstracts of five case histories support the concept that there is a psychosomatic component in addition to the organic pathogenic mechanism in primary glaucoma.

CASE ONE

A fifty-year old woman reported to the office at yearly intervals because she was "so worried about glaucoma." Her father had gone blind with glaucoma and this fear haunted her. Ocular tension, visual fields and fundi had always been within normal limits. She had been taking care of an invalid sister who eventually died. *The day after the funeral the patient developed acute glaucoma in the right eye.* Despite pilocarpine in the other eye, the left eye developed acute glaucoma the day following surgery on the right.

CASE TWO

A sixty-year old woman took a bus to a distant city to visit her daughter. The bus stalled on the highway during a hurricane. She remained on the bus for twelve hours and watched the water slowly ascend above the wheels into the floor of the vehicle. The bus later proceeded to the city and the next day the left eye was painful and sightless. She was treated for conjunctivitis. By the time she was seen by an ophthalmologist, she had acute congestive glaucoma in both eyes.

CASE THREE

A fifty-eight year old woman had lost (through misunderstanding and neglect) most of her useful vision in the left eye from an acute glaucomatous attack. She was tense, apprehensive and fearful about her right eye. All the provocative tests for glaucoma in the right eye were normal. She was reassured on many occasions that her eye was not glaucomatous. Her husband was a chronic complainer and an old hypochondriac. Following severe domestic strife and discord one evening, the right eye developed acute glaucoma. The tension was normalized with miotic therapy and a peripheral iridectomy was done a month later which permanently relieved her elevated ocular tension.

CASE FOUR

A fifty-five year old man who had worked at the same establishment for many years heard that he was to be dismissed. He was always considered a highly "nervous" person. His eyes on previous visits to the ophthalmologist had always been normotensive. Pain was noted in the left eye just twenty-four hours after the rumor started. The eye became acutely congested and the tension was 65 millimeters Schiotz. Miotic therapy brought the tension under control and he has been free of acute elevations for the past seven years. He learned while under treatment for glaucoma that his associates had been fooling him about the loss of a job.

CASE FIVE

A sixty-eight year old woman lost the vision of the right eye following glaucoma surgery years ago. The left eye has been under observation for many years and remains normotensive under miotic therapy. With her normal living routine the tension remains within satisfactory limits. She is very tense and emotional with considerable anxiety about her sole remaining eye. Each time she plans her yearly trip to Florida in November, her tension which had been normal since spring becomes elevated. News of a sick friend or death of her sister has had a similar effect. Intra-ocular tension will rise with each stress situation. Her tension response to each overt emotional crisis is so direct and consistent, that the patient has learned to increase the frequency of the miotic therapy every second hour until the crisis has passed.

There is ample anatomic and physiologic evidence of the cortical control of the vegetative nervous system through hypothalamus. The autonomic and somatic nervous systems have connections which can be demonstrated at many levels. Emotions produce responses in both nervous systems (Kennard[9]). In a comprehensive review of the experimental data on the anatomy and physiology of the hypothalamus, Ingram[4] concludes that this portion of the brain contains important integrating mechanisms for the vegetative functions.

Many of these mechanisms produce their effects by influencing lower subordinate complexes. In turn, the hypothalamus is undoubtedly under control by higher regions including the cerebral cortex.

Weinstein and Foldes[10] express their conception of a glaucomatous attack as an acute capillary dilatation within the eye of a vasoneurotic personality. This concept requires a well-reacting elastic vessel wall and not the damaged vessel wall of the arteriosclerotic. According to their 1934 statistics, 80 per cent of acute congestive glaucoma occurs in climacteric women suffering from essential hypertension.

In cats, with the help of the Horsely-Clark-Szentagotory sterotactic brain localizing apparatus, maximum pupillary dilatation has been produced with a simultaneous rise in ocular tension and blood pressure. This followed electrical stimulation of the hypothalamus about the region of the corpus mammillare and as an experimental demonstration, it suggests the central origin of an acute glaucoma attack.

Egan[13] discusses the role of direct and indirect trauma in the precipitation of acute glaucomatous attacks. Four case histories are cited. The trauma in all cases was a fall. The decreasing depth of the anterior chamber and the swelling of the senile lens were suggested as important factors. Egan believes that the term "shock glaucoma" should include all glaucomatous states precipitated by emotional tension and anxiety whether the trauma be psychic or physical.

In explaining the hypothalamic functions in psychosomatic interrelations, Grinker[15] states that "as a cephalic representative of the autonomic nervous system, the hypothalamus has to do with the energies of visceral origin which are the forces of instincts." Evidence is accumulating to show the close relationship between intra-ocular vascular circulation, the secretion of intra-ocular fluid, the level of intra-ocular tension and their control by the autonomic nervous system (Harrington[3]).

Schoenberg[6] summarizes his experience with the role of anxiety in primary glaucoma by implicating the adrenal and pituitary glands as well as the higher centers of the autonomic system, the hypothalamus and cortex.

A RECENT study of the personality patterns in twenty-seven selected cases of glaucoma demonstrates that more than two-thirds of the patients showed marked deviations on one or more of the personality scales as measured by the Minnesota Multiphasic Personality Inventory. In many instances the personality deviations were so severe as to suggest behavior bordering on the psychotic (Hibbeler[7]).

Piers (cited by Weiss and English[8]) found in 24 of 36 glaucoma cases a close connection between the glaucoma attacks and specific emotional events to which these individuals were especially sensitive. In 9 cases the original attack was precipitated by witnessing an accident which resulted in the injury or death to someone with whom the patient had intense emotional ties.

Schmerl and Steinberg[12] have shown the effect of multiple stresses on rabbit's eyes. They were able to produce an acute rise in ocular tension. The stimuli were light, Citronellol®, Hyperiesin®, a pituitary hormone and distilled water. The increase in ocular tension represented a summation of effects of all the stimuli. When the ocular tension reached a critical point (which was 10 millimeters for the rabbit) manifestations consistent with acute glaucoma appeared in these animals. Some of their stimuli were reported as increasing intra-ocular tension 2 to 6 millimeters. While it seems unlikely that such critical levels or variations in tension could be measured that accurately, nevertheless, the experiments will stimulate further observation in this direction.

Once the diagnosis of glaucoma has been made, the patient is committed to visiting his ophthalmologist at regular intervals for the rest of his life. These regular visits provide an opportunity for reassurance, reeducation, persuasion, verbalization, confession of minor incidents and good physician-patient relationship. This kind of emotionally supportive treatment is, of course, a form of superficial

psychotherapy and should be frankly recognized as such. Furthermore, the patient should know—or be taught—that his diseased eye may be made worse by "aggravating" life situations.

The possibility of the central origin of an acute glaucomatous attack has been referred to many times. Since the hypothalamus is an important center for our neurovegetative and emotional reactions, several of the more recent drugs were tried as a preliminary step in the control of stress associated with increased ocular tension. Rauwolfia and chlorpromazine were selected by the author on the basis of their unique depressant action on both the central and autonomic nervous systems. The effectiveness of these drugs and (especially chlorpromazine) was high. Further studies and observations are being made since the present number of cases does not warrant a conclusion. The use of the drugs so far has been limited chiefly to chronic glaucoma where stress is a factor in causing additional rises in tension. The relief of stress in acute glaucoma is particularly desirable.

SUMMARY

1. The importance of emotional factors in glaucoma, especially in the precipitation of the acute attack, is recognized by every ophthalmologist. Many authorities have cited instances of the close relationship between glaucoma and emotional trauma. Every ophthalmologist can duplicate such case histories from his own experiences.

2. Psychosomatic medicine is based on the assumption that emotions induce physiologic changes. These changes do not always correct themselves sufficiently but may become incapable of reversal and thus help produce structural or organic changes.

3. Psychosomatic manifestations in ophthalmology fall into two categories: the conversion symptoms such as blepharospasm, asthenopia and photophobia; and neurovegetative dysfunctions such as glaucoma, migraine and central angiospastic retinopathy. The neurovegetative functions are under control of the autonomic nervous system. The important integrating mechanism for vegetative or autonomic functions is the hypothalamus. This is intimately connected with higher centers in the cerebral cortex. Since the emotional mechanism is beyond voluntary control, the autonomic system is undoubtedly implicated.

4. There is a close relationship between intra-ocular vascular circulation, the secretion of intra-ocular fluid, the level of intra-ocular tension and their control by the autonomic nervous system. A psycho-analyst has reported in two-thirds of a series of glaucoma cases, a close connection between glaucoma attacks and specific emotional events to which these individuals were especially sensitive.[8]

5. Five case histories are recited to illustrate the effect of emotional excess in the precipitation of acute glaucoma. A similar mechanism probably is effective in chronic glaucoma.

6. The recognition, understanding and interpretation of the effect of psychic trauma, anxiety and stress in glaucoma will lead to a more fundamental approach to the problem and to a better ophthalmologist-patient relationship.

7. Preliminary tests of the use of rauwolfia and chlorpromazine are encouraging. They suggested real clinical usefulness for their tranquilizing action on the central and autonomic nervous systems in certain cases.

1616 Pacific Avenue

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Board of Trustees Meeting

At its June 16 session, the Board:

—Voted to maintain the general account of the Society in a Trenton bank or banks at the discretion of the Finance and Budget Committee.

—Agreed to make the facilities of the Executive Offices available to the State Board of Medical Examiners at a nominal service fee.

—Discussed the request that physicians lecture at the annual refresher courses for chiropractors given at Rutgers University. The Board reaffirmed its action of 1955 disapproving participation of M.D.'s in the activities of chiropractors or other cultists.

—Authorized a meeting of representatives from our Society with representatives from Self-insured employers, the State Department of Labor, and insurance companies to develop appropriate medical forms for use in workmen's compensation claims.

—Approved a change in the VA fee schedule which would set a surgical assistant's fee as 25 per cent of the surgeon's fee instead of, as heretofore, as a flat $15.

—Authorized the following policy with respect to establishing our Society's position in emergency matters:

> At any time when need for emergency action arises on matters having to do with The Medical Society of New Jersey and/or its Woman's Auxiliary, the officer or chairman of a committee desiring emergency action should call the Executive Offices in Trenton who will in turn communicate with the presidential officers and chairman of the Board of Trustees for approval.

—Sent acknowledgments (for their part in the New York reception for Dr. Allman and in the maintenance of our Hospitality Room) to Pfizer Laboratories, L. N. Renault & Sons, Owens-Illinois Glass Company, Orange Publishing Company, Atlantic City Convention Bureau, Woman's Auxiliary, and The Waldorf-Astoria.

—On the basis of the report of an *ad hoc* committee, approved of permitting Pfizer Laboratories to televise the play-off of the New Jersey Physicians Golf Tournament.

—Authorized renewal of the "Medicare Program" contract.

—Recommended that efforts be made to develop Woman's Auxiliaries in Morris and Sussex Counties.

—Approved the payment of $600 to the Society's counsel for extraordinary services rendered in an appeal hearing before the A.M.A. Judicial Council.

—On recommendation of the Subcommittee on Legislation, took the following action with respect to certain bills pending in the state legislature:

S-153 *Jones*—To establish a Division of the Aging to study and coordinate programs and services for older persons. *No Action*

S-165 *Dumont, Fox*—To authorize the promotion of certain medical officers of the New Jersey National Guard. *No Action*

S-166 *Shershin*—To deem specified illnesses of motor vehicle inspectors to be occupational diseases. *Disapproved* It would be diagnosis by legislative enactment.

S-167 *Shershin*—Companion bill to S-166. To deem specified illnesses to be accidents in the course of employment. *Disapproved* It would be diagnosis by legislative enactment.

S-198 *Jones* and A-340 *Brady*—To require that garbage to be used as food for hogs being raised for commercial sale be cooked to destroy larvae causing trichinosis and to impose penalties for violations. *Approved*

SJR-7 *Crane*—To declare May as "Golden Deed Crusade Month for Cerebral Palsy." *No Action*

SJR-13 *Dumont*—To create a twelve-member Workmen's Compensation Insurance Coverage Study Commission to study among other things whether public insurance would improve the present system. *No Action*

A-370 *Newton*—To permit chiropodists to perform bone resections and to treat fractures and dislocations of the foot. *Disapproved Active Opposition if bill moves*

> This measure is identical with A-524 of 1956 concerning which our position was one of "disapproval . . . active opposition if bill moves."

A-385 *Kurtz*—To exempt certain medicinal preparations containing limited amounts of noscapine and papaverine from narcotic control restrictions. *Approved*

A-389 *Lazzio*—To extend temporary disability benefits coverage to periods of care by chiroprac-

tor. *Disapproved* This would involve extension of the scope of chiropractic. A-390 is disapproved for the same reason.

A-390 *Lazzio*—To extend workmen's compensation coverage to periods of care by a chiropractor. *Disapproved*

A-404 *Goff*—To authorize the State House Commission to contract for insurance providing hospital, medical, and surgical expenses benefits to state employees without cost. *No Action*

A-435 *Lazzio, Vervaet*—To authorize counties to provide community mental health services under certain conditions with the state meeting up to 50 per cent of the cost of approved projects. *No Action*

ACR-35 *Vervaet*—To reconstitute the State Commission on Mental Health. *Approved*

ACR-33 *FitzMaurice*—To memorialize the United States Food and Drug Administration to review approval of sale without prescription of tranquilizing drugs and to recommend necessary changes in the law. *Approved*

—Submitted to the Governor names of members for consideration for appointment to the State Board of Medical Examiners.

—Appropriated $10 as a contribution to the New Jersey Citizenship Conference, 1957.

—Declined to endorse a fund drive by the Seton Hall College of Medicine and Dentistry and declined to endorse a campaign to obtain a legislative appropriation for a new science building at Rutgers. Endorsement in either case would be a violation of the Society's long-standing policy of not using the Society's name to endorse such activities.

—Authorized Dr. Carl Ware to review and sign expense vouchers submitted in the absence of Dr. Allman.

—Submitted to the appropriate committees a number of resolutions and recommendations from the May 1957 session of the House of Delegates.

Convulsive Disorder Consultation Service

The New Jersey Consultation Service for Convulsive Disorders announces the removal of its offices from Newark to the New Jersey Neuro-Psychiatric Institute, Box 1000, Princeton, N. J. This service has been operating since 1953 and is an outgrowth of a plan originating with The Medical Society's Advisory Committee on Mental Hygiene and approved by the Board of Trustees in 1950. Clinics are held one day each week rotating among the four state health district areas of the state.

Reports and recommendations are sent back to the referring physician. This is a consultation service only. Treatment of the patient remains with the community physician. Follow-up is provided by public health services and community welfare agencies.

Referral forms can be obtained from the New Jersey Neuro-Psychiatric Institute. The Consultation Service has been absorbed by the State Department of Institutions and Agencies which will assume primary responsibility for operating this service.

New Jersey Obstetricians Certified

Fourteen New Jersey physicians were certified by the American Board of Obstetrics and Gynecology at their May 1957 meeting. The obstetricians and gynecologists so certified were:

Ted W. S. Chong, Camden
Sidney Cohn, Passaic
Robert E. Davis, Morristown
Ralph W. Ellis, Trenton
Charles D. Foster, III, Woodbury
Robert A. Haines, Camden
Raymond E. Jacobus, Asbury Park
Myles C. Morrison, Jr., Morristown
Frank D. Newell, Summit
Olindo W. Rosanelli, West New York
Alan M. Schaeffer, Delanco
William R. Sillery, Grantwood
Harold G. Spence, Summit
Charles R. Walsh, South Orange

Announcements • • •

Anatomic-Pathologic Society

The Essex County Pathologic and Anatomic Society celebrates its 50th anniversary on Saturday, November 9 by an all-day and evening program in Newark. This will provide a rich intellectual feast for all who are interested in medicine. Obtain further details from Dr. Charles Englander, 41 Hillside Avenue, Newark.

Nutrition Conference

An all-day conference on Nutrition and Disease will be held in Philadelphia on Sept. 30. For detailed program, write to Dr. Michael Wohl at 1727 Pine Street, Philadelphia 3, Pa.

Interested in Forensic Medicine?

The New Jersey Medico-Legal Society launches its second year with a meeting on October 9, to be held at the Rutgers University Law School, Washington Street and Washington Place, in Newark. Physicians who are interested in medical jurisprudence or forensic medicine are invited to join the Society. Details may be obtained from the secretary, Dr. Frederick S. Barnes, 786 Park Street, Newark 4, N. J.

Gastroenterology Course in Philadelphia

Announcement is made of a course in gastroenterology to begin November 6 and run for 12 Wednesdays thereafter. The lectures and demonstrations will be held from 3 to 5 p.m. Fee for the course is $50. Registration deadline is October 26. The course is sponsored by the Albert Einstein Medical Center at York and Tabor Roads, Philadelphia, and more details may be obtained from the chairman of the graduate committee of the Medical Center at that address.

Internal Medicine Course

A course on recent advances in internal medicine and therapeutics will be sponsored by the Academy of Medicine of New Jersey and the Middlesex County Chapter of the American Academy of General Practice, with the cooperation of Middlesex General Hospital, New Brunswick, N. J. The 36-session course begins on Wednesday, September 25, 9 a.m. to 11 a.m. at the Middlesex Hospital Auditorium. Fee is $100, with a reduced fee for interns and residents.

The course is accepted for credit by the American Academy of General Practice. For more information, write to resident director for the course—Dr. Sylvan E. Moolten, Middlesex General Hospital, New Brunswick, N. J.

Surgical Convention in Atlantic City

The Clinical Congress of the American College of Surgeons will be held this year in Atlantic City. The Congress starts on October 14 and runs for four days. It includes graduate courses, surgical seminars, and technical exhibits. Full details may be obtained from the headquarters of the American College of Surgeons, 40 East Erie Street, Chicago 11, Ill.

Psychosomatic Meeting

For the first time in this country a convention will be held at which all of the various specialties will integrate their contributions to offer a single psychosomatic program. This year's session covers the psychosomatic aspects of gynecology and endocrinology. The meeting will be held in Chicago, October 17, 18 and 19. To obtain further information, write Dr. William S. Kroger, 104 S. Michigan Avenue, Chicago 3, Ill.

Hawthorne Surgical Society

The Hawthorne Surgical Society, which is an honorary fellowship of qualified surgeons who are alumni of the Graduate School of Medicine of the University of Pennsylvania, will hold its Fifth Annual Meeting on October 16 at the Shelburne Hotel in Atlantic City. Reservations should be forwarded to: Julian A. Sterling, M.D., 1008 Sharpless Road, Phila. 26, Pa.

Symposium on Nutrition in Pregnancy

Nutrition in pregnancy will be the subject of the 1957 symposium of the Council on Foods and Nutrition of the American Medical Association to be held October 11 at the University of Missouri Medical Center, Columbia, Missouri. For further information, write to the Council at 535 N. Dearborn St., Chicago 10, Illinois.

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Urology and Industry. By L. P. Wershub, M.D. Pp. 176. Springfield, Ill., C. C. Thomas, 1956. ($5.00)

The author of this book has, in a very concise and forceful way, condensed a full and varied combination of studies into his free-flowing and easily read text.

His brief but inclusive description of the evolution of industrial medicine, and of the development and reasons for the need for workmen's compensation, is well worth the short time necessary for its perusal. The book includes case reports with pertinent comments and an excellent review of the urologic field. The text is of great value to the industrial physician or general practitioner. The comments are very simple, concise, and informative. The book will be a useful addition to any hospital library. It is especially valuable to the physician doing any industrial work, and it is a must for the full time occupational physician.

ARTHUR F. MANGELSDORFF, M.D.

Dorland's Medical Dictionary. Edited by Leslie Brainerd Arey, Ph.D., William Burrows, Ph.D., J. P. Greenhill, M.D. and Richard M. Hewitt, M.D. 23d edition. Pp. 1598. Saunders, Philadelphia, 1957. ($12.50)

Among the three major American medical dictionaries it would be odious to make comparisons. However, Dorland's is now in its twenty-third edition and obviously has been giving satisfaction to medical students and practitioners. The 1957 edition is of handy size, and although it contains 1600 pages it is printed on fine, thin paper so that it is not unwieldy. The book is particularly rich in plates, diagrams and tables. The definitions are short, compact, and authoritative, although of course vary somewhat in their accuracy since dozens of different contributors wrote them. Etymologies are given for all the words defined and there is a useful table of drugs and dosage in the appendix. Dorland's table of tests is unique in medical lexicography. The illustrations are mostly line drawings and are clean and clear. It is assumed that every practicing physician has a medical dictionary at his finger tips. It is impossible to be a literate physician without one. If you don't have a dictionary, or if you have a prewar edition, now is the time to get the 1957 Dorland's.

HENRY A. DAVIDSON, M.D.

Headache: Management of the Patient. By P. S. MacNeal, M.D., Bernard J. Alpers, M.D. and William R. O'Brien, M.D Philadelphia 1957. Lea and Febiger. Pp. 146. ($3.50)

Headache is every doctor's headache. The Jefferson Medical College group here discuss the mechanism, diagnosis and treatment of migraine, vascular, intracranially caused, tension and psychogenic headache. There is an unfortunate overuse of trade-names so that some of the pages sound like a detail man's talk. One wonders why they have to use the trade-names (specifying certain brands) for such drugs as ergotamine tar-

trate, methyl octenylamine, and rauwolfia root. The text includes a compact monograph on postconcussion headache, a brief but remarkably lucid explanation of psychotherapy and an interesting discussion of "tension headache," which the authors distinguish from "psychogenic headache." Both the psychotherapeutic and the pharmaceutical methods of treatment of migraine are discussed (apparently by different authors). Altogether a useful little volume.

ABRAHAM LEFF, M.D.

Experimental Psychology and Other Essays. By Ivan Petrovich Pavlov. Translator's name not stated. New York, 1957, Philosophical Library. Pp. 653. ($7.50)

No one doubts medicine's debt to Pavlov. But it is, perhaps, usurious payment on that debt to expect any 20th century physician to wade through this mish-mash of essays, autobiography, tabulations, lecture notes and conversational fragments. Some of the experimental work is reported in frightful detail. Thus we learn the pressure in the right carotid artery of a rabbit curarized in 1874, the pressure being here reported to us at 30 second intervals from 1 hour 07 minutes to 1 hour 24 minutes and 30 seconds. The stuff is of no usable value today, and its interest is exclusively historical. The translation is awkward. ("The cerebral hemispheres *is* a rather impressive organ" — this as a typical example of bad translation and an obvious generality). To the medical historian, this is a useful, if somewhat tedious source book. The clinician might enjoy reading it, provided, of course, that he is a masochist.

HERBERT BOEHM, M.D.

Hutchison's Clinical Methods. By Donald Hunter, M.D. and R. R. Bomford, D. M. Ed. 13. Philadelphia 1957. Lippincott. Pp. 452 with 100 illustrations, figures and plates. ($6.00)

Since 1897, Hutchison and Rainey have been guiding practitioners, teaching medical students and tipping off interns. Few current medical texts can boast of 60 years of constant usage. The excellence of the original plan, and the sensitivity of the editors to changes in medical practice, have resulted in constant revision. The current edition is true to the tradition of Hutchison and Rainey, though it is now more properly, called Hunter and Bomford. The book includes a useful guide to history taking, a down-to-earth technic for physical examination, and explicit directions on the taking and interpretation of the commoner tests of blood, urine, sputum, feces and other body fluids and tissues. There is special consideration of skin tests, of the handling of children, and of the preparation of test solution. There is useful material on interpreting heart sounds and reading electrocardiograms. All this is packed into a 5 by 7½ volume than can be slipped into a large pocket. A useful pocketful it will be!

VICTOR HUBERMAN, M.D.

Expectant Motherhood. By N. J. Eastman, M.D. Pp. 198. Ed. 3. Boston, Little, Brown, 1957. ($1.75)

This third edition of *Expectant Motherhood* has a wealth of information condensed in less than two hundred pages. The wording is in lay language, making the book easy to read and to understand. It includes everything from embryology to the care of the newborn.

Dr. Eastman corrects many of the "old wives' tales," and his sidelights on medical history help to make the book interesting. Those of us who remember Dr. Brigham and his work on diet and weight control in prenatal care will appreciate the chapters on diet and pregnancy.

The patient's questions on Rh, anesthesia, and natural childbirth are all answered in a satisfactory manner.

All in all this teacher has produced an excellent book for the new mother as well as the doctor. For the latter it is a quick review and for the doctor who delivers an occasional case it informs him what is to be expected from good prenatal care.

FRANCESCO SBARRA, M.D.

Obesity: Its Cause, Classification, and Care. By E. Philip Gelvin, M.D., and Thomas H. McGavack, M.D. Pp. 146. New York, Harper and Brothers, 1957. ($3.50)

The authors intended that this small book should present a "practical program for the management of obesity." It falls short of this expectation. It is, rather, a summary of the current literature on this subject, supplemented with some of the author's personal experiences.

The bibliography was well chosen, and in each instance, a sentence or two prepares the reader for what may be expected in the original articles.

The subject is presented in a clear, integrated manner and lends for easy reading. The book can be read in an hour. There are numerous practical thoughts on the mundane aspects of management. The average doctor reading this book would find many familiar observations and expressions which he has seen and heard in his own office.

The authors offered nothing new in the form of treatment, which is, at present, in an inadequate stage.

S. WILLIAM KALB, M.D.

TUBERCULOSIS Abstracts

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Vol. XXX September, 1957 No. 9

Minimal Pulmonary Tuberculosis in Military Personnel: World War II

By James Waring, M.D., and William H. Roper, M.D., The American Review of Tuberculosis and Pulmonary Diseases, January, 1957.

The mobilization and maintenance of the Army of the United States in World War II, with initial physical examination of all accepted military personnel and subsequent medical control and hospitalization as necessary, provided an exceptionally valuable opportunity for studying the fate of tuberculous lesions. The medical provisions of the mobilization regulations, permitting acceptance of men with small densely scarred lesions, and the occurrence of active tuberculosis in the military forces as a result of failure of detection on entry or new acquisition of the disease during service, made it possible to study in a known military environment, the progress of tuberculous lesions that became manifest under conditions ranging from sedentary occupations to the extreme physical strains of military combat.

The study here described was set up to take advantage of this unusual opportunity. Its findings are of interest and value at the present time for comparison with currently accumulating data on the course of pulmonary tuberculosis of similar character as affected by methods of treatment (specific chemotherapy) not available at the time of this study.

A research organization was established that would permit observation over a period of years of a group of a thousand men and women with pulmonary tuberculosis in the minimal stage at the time of its first detection, or with reliable records furnishing objective evidence of its presence in that stage at some previous period, *e.g.*, in an army induction station examination in which the lesion was overlooked. A group of approximately this size was selected and a system of follow-up was set up for a period of three years or more. Because of the nature of the material, the observations were oriented on a military basis. In essence, however, they apply equally well to tuberculosis in a nonmilitary environment.

This study of minimal pulmonary tuberculosis as it occurred in the U. S. Army during World War II was begun in January, 1944; the last patient was included in the project in June, 1946, preceding the era of chemotherapy for tuberculosis. Observations were continued until September, 1949. The primary purpose of this study was to ascertain what happened under war conditions to military personnel developing minimal pulmonary tuberculosis while in service. It was also hoped to determine the reliability or unreliability of certain criteria for acceptance or rejection of recruits for military service, such as roentgenographic abnormalities and previous history of active tuberculosis.

After excluding the 35 persons who died during the study, the average follow-up period was 52 months for each person. Chest roentgenograms taken on entry into the army were reviewed for 918 of the 967 military personnel under observation. During the follow-up period, every person in the group was examined three to six times annually for three or more years, and more than 28 films per person were reviewed.

The method of selecting patients for study is believed to have yielded a valid random sample of minimal pulmonary tuberculosis in the army. For example, the median age of all patients included in this study was 28.2 years, compared with 28.8 years for the patients with minimal disease in the army as a whole during the same period.

Of 625 persons with active minimal tuberculosis at the time of the first clinical classification by the Army Research Section, the disease improved in one-third and worsened in two-thirds during the period of observation. Of 342 persons with apparently inactive tuberculosis at first

study, 78 per cent remained well, 9 per cent had relapses and later improved, while 13 per cent had relapses with subsequent worsening of their disease. The proportion of active cases in which improvement occurred was highest in the group 25 to 34 years of age.

Eighty-two persons developed active pulmonary tuberculosis within twelve months and 31 of them within six months after entry into military service. Despite "acceptable" roentgenograms, the majority of those with histories of active tuberculosis before admission to the army in World War II had relapses during military service. Of 94 persons with histories of pre-military active tuberculosis, 68 had relapses during service or after discharge. The probability of relapse was greatest in those with histories of pleural effusion in those with previous extrathoracic tuberculosis, and in those who had less than six months of rest treatment. On the other hand, 30 of the 112 persons with histories of active tuberculosis in the pre-military period remained well while in service and did not experience a relapse subsequently in the period of observation. Unless adequately treated before return to duty, the hazard of relapse during military service after apparent recovery from active tuberculosis is great. The figures involved are admittedly small. These observations were made before chemotherapy became available.

Persons with calcific elements in the parenchymal lesions shown on entry roentgenograms did better in every way than would be expected on the basis of chance alone. In the absence of pre-military skin tests, the implications of this observation are uncertain. In the estimation of activity and potential reactivation, the number, distribution, size, and character of intrathoracic lesions are not as helpful as roentgenographic evidences of stability or instability of the lesions. The value of a negative tuberculin test has been emphasized. Abnormal physical signs and symptoms were not very helpful in diagnosis. In 391 (63 per cent) of the 625 persons with active tuberculosis at first examination, initial recognition of active pulmonary tuberculosis with no suspicious symptoms was due to routine roentgenograms of the chest.

Among the active cases the duration of overseas service bore little relation to "breakdown" with active disease or to the subsequent course of disease. Persons engaged in combat fared the worst, while those assigned to light or moderate work outside without combat duty fared the best.

Assignment of "poor risks" to limited duty within continental United States seemed to afford a measure of protection. Persons with active tuberculosis on limited duty did no better, however, than those on general duty. These findings substantiate the general medical opinion that heavier physical exertion increases the likelihood of "breakdown" with tuberculosis and also increases the likelihood of worsening in active disease.

The type of onset, with or without symptoms, did not bear a significant relationship to the course of disease; one-half of those presenting symptoms proved to have inactive tuberculosis. Persons with persistent rales were more apt to have recurrence of activity than those without rales. Single erythrocyte sedimentation rates did not prove helpful. "Active" cases with sputum persistently negative for tubercle bacilli did better than "active" cases with sputum positive for tubercle bacilli.

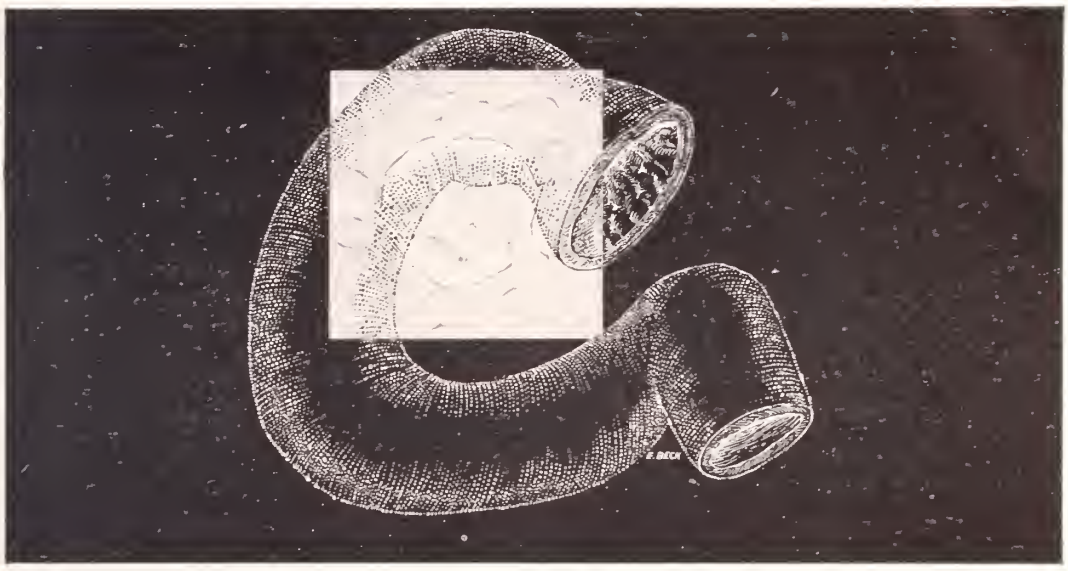
Patients with longer periods of hospitalization did much better than those treated for less than six months. Approximately 96 per cent of all observed relapses occurred within the first three years after the end of treatment for the military episode of active disease. Relapses included practically all forms of intra- and extrathoracic tuberculosis.

At the end of the follow-up period in September, 1949, of 625 persons with active minimal tuberculosis at first observation, 370 were well, 228 had active disease, 16 were dead of tuberculosis and 11 had died of other causes. Of 342 with inactive minimal tuberculosis, 262 were well, 72 had active disease, 4 were dead of tuberculosis and 4 had died of other causes. Of the 342 rated inactive at first observation, 75 had relapses and had active disease.

In brief, of those diagnosed as having active tuberculosis at the time of the first clinical examination by the Army Research Section, 59 per cent were alive and well at the end of the period of observation, compared with 77 per cent of those diagnosed as having apparently inactive disease.

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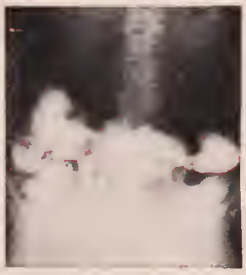
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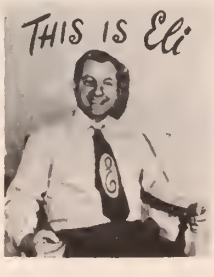
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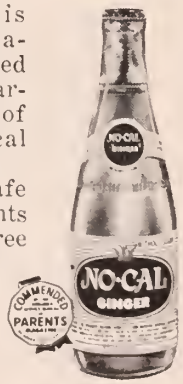


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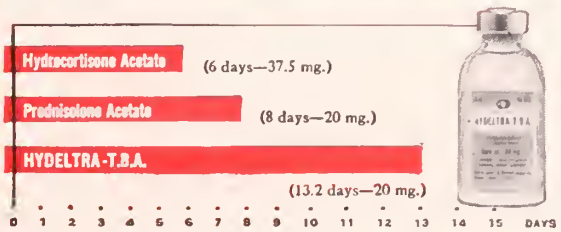
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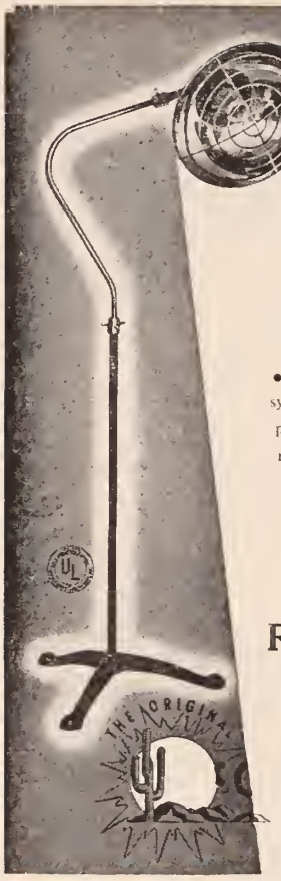
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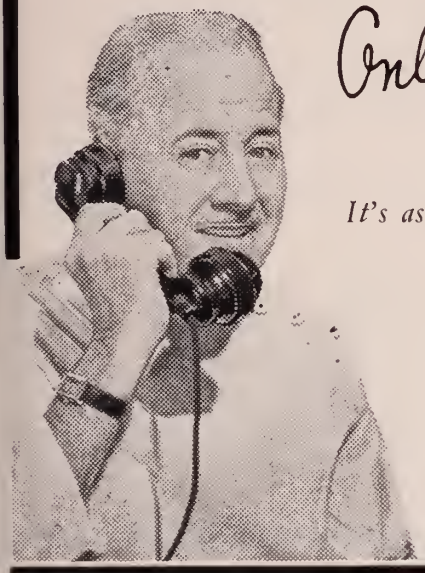
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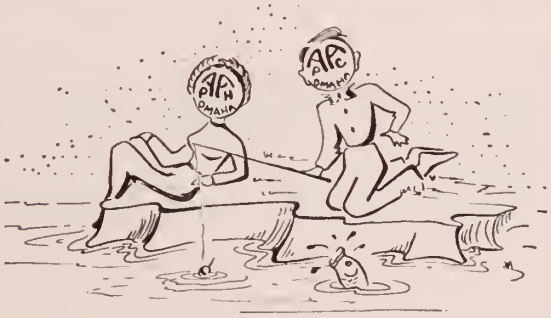
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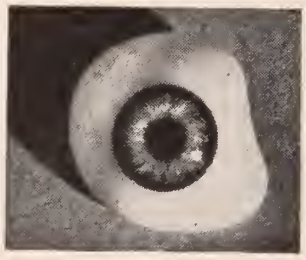
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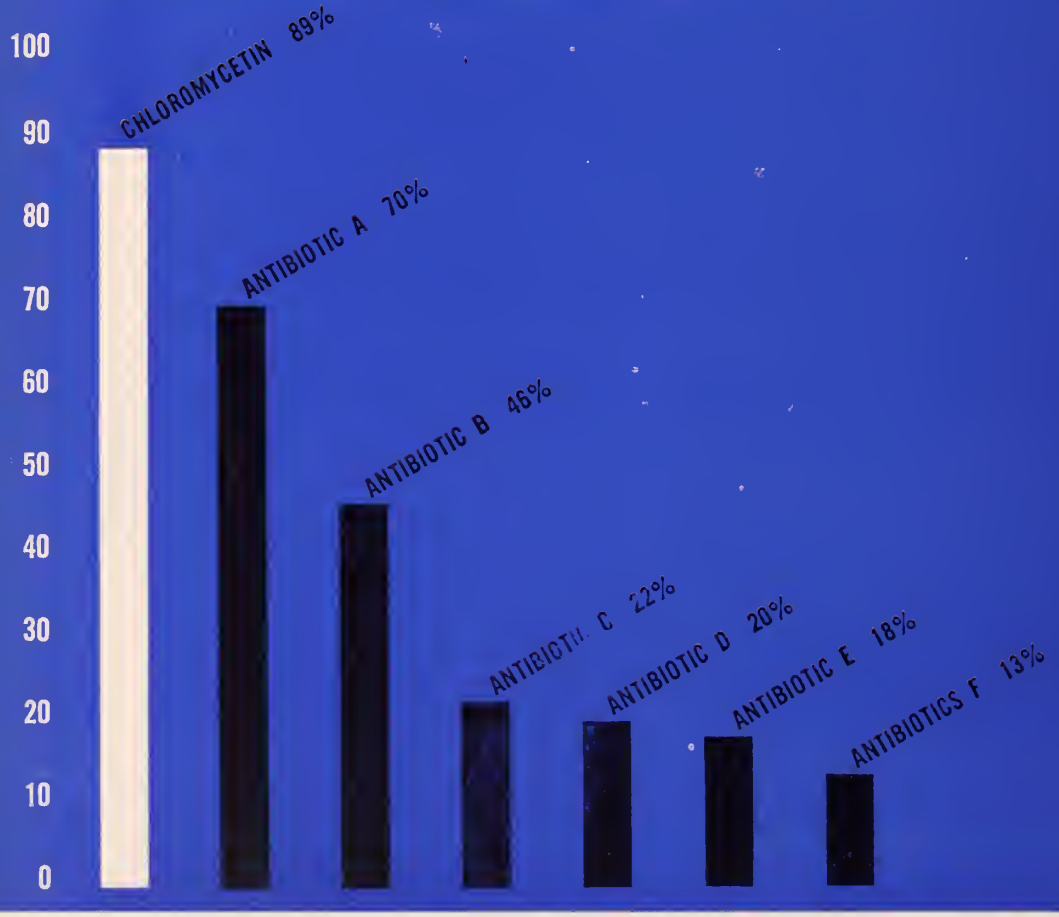
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A REPORT ON A PROMISING CONCEPT IN ANTIMICROBIAL THERAPY: CONCURRENT ADMINISTRATION OF CHLOROMYCETIN AND GAMMA GLOBULIN

In treatment for infection, the physician is confronted with complex interactions between pathogen, antimicrobial agent and host. The pathogen represents the unselected factor, the therapeutic agent the component over which the physician exercises maximum control. But even with optimal antibiotic therapy, the eventual elimination of the infective agent and the resolution of pathologic changes depend upon efficient host response.[1,2]

Passive transfer of antibodies through gamma globulin provides a broad antibacterial spectrum because of origin in adults exposed to a variety of microorganisms. Employed as a protective element against some of the more common contagious diseases, gamma globulin permits more competent participation by the host in the fight against established infection.

Rationale for immuno-antibiotic therapy lies in simultaneous direct attack on the pathogen and re-enforced host resistance, which implies usefulness in treatment for acute fulminating, highly refractory, or prolonged infections.

EXPERIMENTAL STUDIES ENCOURAGING

In carefully controlled studies in mice, Fisher and his colleagues in Parke-Davis Research Laboratories, using pooled human gamma globulin and Chloromycetin (chloramphenicol, Parke-Davis) concurrently, demonstrated a high degree of therapeutic effectiveness in infected animals.[3] Five types of infection induced with species of Staphylococcus aureus, Streptococcus pyogenes, Proteus vulgaris and Pseudomonas aeruginosa responded to joint therapy with gamma globulin and Chloromycetin, each agent having shown at deliberately low doses in previous work little or no activity in these mouse infections when used separately. Fisher's experiences with hemolytic streptococci have been confirmed.[4]

Tests now in progress with pneumococci, salmonellae and additional strains of pseudomonas and proteus indicate that marked increases in survival rates may be anticipated in any infection where chloramphenicol has previously demonstrated therapeutic activity.[3] These observations suggest that immuno-antibiotic therapy can effect cures in a variety of refractory microbial diseases.

PROMISING IN EARLY CLINICAL TRIAL

Observations analogous to those of Fisher have been reported from the clinic.[5-7] More recently, the clinical use of gamma globulin in conjunction with antibiotics was undertaken by Waisbren[8] on the basis of Fisher's experimental work. His series of 46 patients with systemic and localized infections due to various strains of staphylococcus, pseudomonas, salmonella, proteus and to the pneumococcus had failed to respond to maximum effort with conventional therapeutic measures. Marked clinical improvement in six of these acutely ill patients shows clearly "...that in certain instances the addition of gamma globulin to antibiotic therapy may give a clinical result that could not have been obtained with the antibiotics used alone. In each of these cases, a long and extensive control period in which antibiotics were being vigorously administered had failed to produce a response but when gamma globulin was given with approximately the same dosages of antibiotic, rather marked improvements occurred."[8]

While the precise mechanism underlying the salutary effect of gamma globulin remains to be clarified, the existence of quantitative hypogammaglobulinemia was ruled out in patients in this series.[8]

A RATIONALE FOR IMMUNO-ANTIBIOTIC THERAPY

Although the relationship of susceptibility to infection and status of the host is well recognized, host resistance is an aspect of infectious disease still not understood in an era of extensive and of massive antibiotic therapy. Most antibiotics, in concentrations tolerated by living tissues, have bacteriostatic rather than bactericidal effect. In the clinic, bacteriostatic doses are most frequently given and host defense mechanisms are responsible for the eventually satisfactory clinical result.[4]

The problem of therapeutic failures despite vigorous courses of antibiotic therapy may be due to some disturbance in the immune process.[9] In addition, disproportionately high mortality rates in the extremes of life lend support to the impression of inadequate defense mechanisms, since these are underdeveloped and immature in the very young and may be impaired or depressed in the aged.[1]

Any discussion of immuno-antibiotic treatment must at present remain largely conjectural. From preliminary evidence, however, this approach to therapy appears worthy of consideration, especially in patients in whom adequate antibiotic therapy for active infectious processes has been disappointing. While the concept of enlisting the aid of the host in combating pathogenic microbes, thereby affording the physician control of two of the three principal interacting factors, is not new, enhancement of host resistance through use of gamma globulin in treatment for microbial disease is indeed a promising one.

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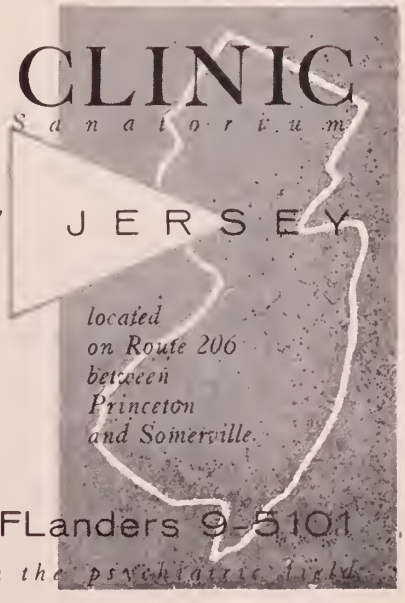
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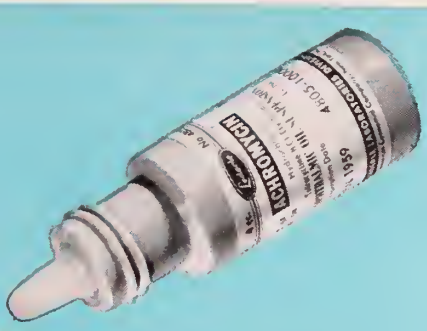
Romilar CF brings new comfort and ease to your patients with colds and other respiratory disorders by providing more complete symptomatic control. Romilar CF syrup combines the benefits of an antihistaminic, a decongestant, and an analgesic-antipyretic with the effective cough suppressant action of Romilar Hydrobromide* — the non-narcotic cough specific with codeine's antitussive effect but without codeine's side effects.

Each teaspoonful (5 cc) of Romilar CF provides:

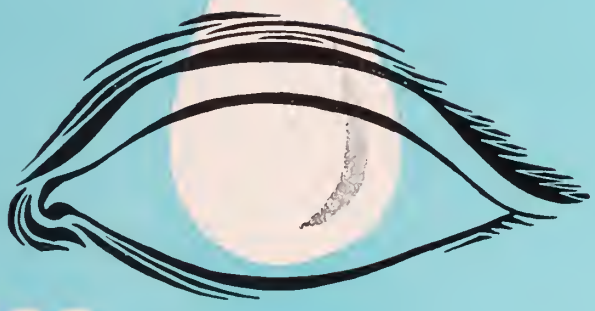
Romilar ® Hydrobromide*	15 mg
Chlorpheniramine Maleate	1.25 mg
Phenylephrine Hydrochloride	5 mg
N-acetyl-p-aminophenol	120 mg

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc
Nutley, New Jersey

*Brand of dextromethorphan hydrobromide



spreads *in a wink!*



NEW ACHROMYCIN* TETRACYCLINE OPHTHALMIC OIL SUSPENSION 1%

bland soothing drops

- floods tissues quickly, evenly
- compatible with ocular tissues and fluids
- eliminates cross contamination
- easily self-administered

supplied:

4 cc. plastic squeeze-dropper bottle containing ACHROMYCIN Tetracycline HCl (1%) 10.0 mg., suspended in sesame oil.

unsurpassed in antibiotic efficacy

- Therapeutic: the true broad-spectrum action of ACHROMYCIN, promptly effective in a wide variety of common eye infections
- Prophylactic: following removal of foreign bodies; minor eye injuries
- Stable, no refrigeration needed; retains full potency for 2 years

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

Lederle

*Reg. U. S. Pat. Off.

Flu Fight

Drug Firms Speed Vaccine Output, Bu Will the U.S. Need

Asiatic Virus Raises Th
Government Buys, I
nd Hens Have to H

en Attack, Rapid S

8 STUDENTS ON FLIGHTS TO U. S. HAVE ASIAN FLU

New York, Aug. 15 (AP) Laboratory tests on e foreign exchange student arrived Aug. 8 show they victims of Asiatic flu, the health department repo today. The eight arrived plane from Europe.

Twenty-nine other stud suffering from influenza rived Tuesday from Rot dam on the ship Arosa Sky. One, Nicholas Memmos, Greek exchange student, die yesterday. Six of these students were released today the others are to be re tomorrow. It has not termined whether died from Asiatic

Pe vac izat flo the ority states

THE INFLUE

How Deadly Will it
What Can We Do a

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U.S. Fighting A

ıe War on Mutant A

'f Florence was in the grip of an epi-nic of colds, coughs and fevers, astrolo-s . . . declared that it was caused by influence of an unusual conjunction of nets. This sickness be known as "infl
—Chronicles of
1200-1470.

To combat new r ence," a worldwide week in respons m the Far East. Si he World Health a, which collects i m around the globe cimens of the ene is. In more than a, uding those of th

Asian Flu: the Outlook

Asian influenza will hit the U.S. this fall before mass immunization can be effective, and the nation faces an epidemic which may strike 15 million to 30 million people. The disease is relatively mild (in no way comparable to the killing "Spanish flu" of 1918-19), and is likely to cause only a small number of deaths among the feeble young and enfeebled old. But it may compel 10% to 20% of the population in affected areas to tak thus

W quie a co pect Ser pop

The War On Asiatic Flu

There's cause for concern about Asiatic flu, but scientists and public health officials see no reason for anyone to panic.

First shipments of the vaccine against the new influenza strain have arrived in Chicago, setting off a flood of telephone calls from worried patients to doctors, and from doctors to drug suppliers. This is a nor pattern of mass fear and is understan

The of the

Even though Salk vaccine priorities were necessary, the regulation produced administrative headaches, public complaints and probably a gray, if not a black market. When regulation i invoke it. would

PUBLIC HEALTH

Influenza

➤ INFLUENZA, one of the mo dictable of communicable disease ing "on cat feet" across the nat now. It has already struck once in mild epidemic form at an base in Colorado. When and ho it will strike again is a perennial public health authorities.

It will probably not be dor the rest of the winter months. At

to counteract
complications from
"ORIENTAL FLU"

EMIC
using It?

ATCH "ASIATIC" FLU—

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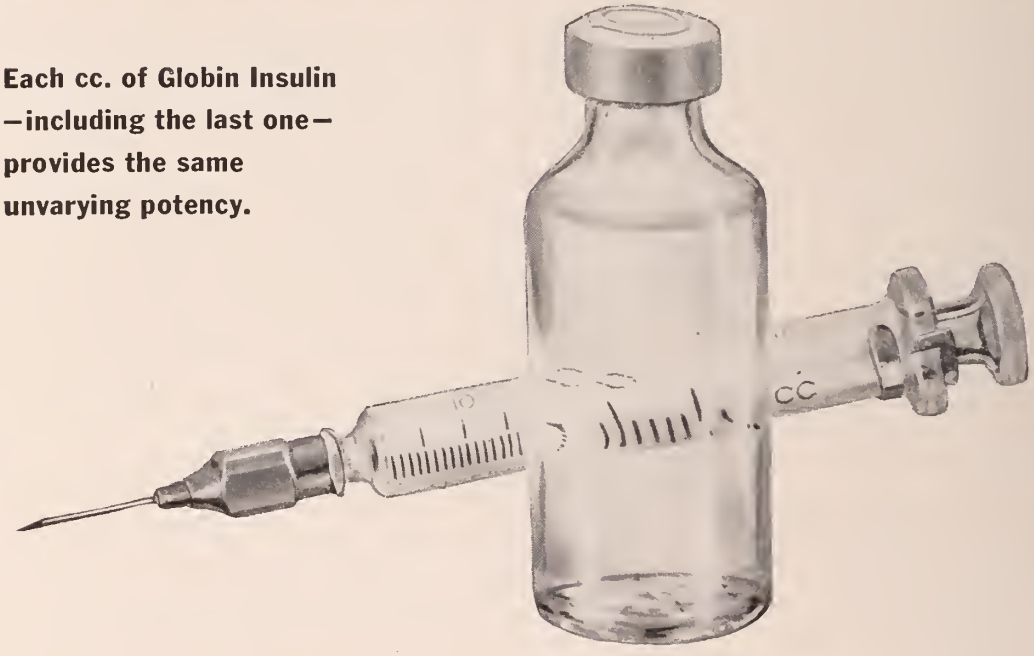
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filmtab®
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STEARATE (Erythromycin Stearate, Abbott)
effective against staph-, strep- and pneumococci
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Avoid "BOTTOM OF THE VIAL" reactions

Each cc. of Globin Insulin —including the last one— provides the same unvarying potency.



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24-hour control for the majority of diabetics

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BURROUGHS WELLCOME & CO. (U. S. A.) INC., Tuckahoe, New York

optimal dosages for ATARAX,
based on thousands of case histories:

25 *mg. (t.i.d.)*

for these **25** *adult indications:*

TENSION **SENILE ANXIETY** **MENOPAUSAL SYNDROME** **ANXIETY** **PREMENSTRUAL TENSION**
PHOBIA **HYPOCHONDRIASIS** **TICS** **FUNCTIONAL G. I. DISORDERS** **PRE-OPERATIVE ANXIETY**
HYSTERIA **PRENATAL ANXIETY** • **AND ADJUNCTIVELY IN CEREBRAL ARTERIOSCLEROSIS**
PEPTIC ULCER **HYPERTENSION** **COLITIS** **NEUROSES** **DYSPNEA** **INSOMNIA**
PRURITIS **ASTHMA** **ALCOHOLISM** **DERMATITIS** **PARKINSONISM** **PSORIASIS**

perhaps the safest ataraxic known

PEACE OF MIND ATARAX®

(BRAND OF HYDROXYZINE)

Tablets-Syrup

10 *mg. (t.i.d.)*

for these **10** *pediatric indications*

ANXIETY **TICS** **HOSTILITY** **NIGHTMARES** **HYPEREMOTIVITY** **RESTLESSNESS**
TEMPER TANTRUMS **HOSPITAL FEAR** • **AND ADJUNCTIVELY IN ASTHMA** **ENURESIS**

Consider these 3 ATARAX *advantages:*

- 9 of every 10 patients get release from tension, without mental fogging
- extremely safe—no major toxicity is reported
- flexible medication, with tablet and syrup form

Supplied:

In tiny 10 mg. (orange) and 25 mg. (green) tablets, bottles of 100.

ATARAX Syrup, 10 mg. per tsp., in pint bottles. Prescription only.

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INTRAVENOUS Compatible with commo IV fluids. Stable for 24 hours in solution at room temperature. Ave age IV dose is 500 mg. given at 12 hour intervals. Vials of 100 mg., 250 mg., 500 mg.



THERAPEUTIC BLOOD LEVELS ACHIEVED

Many physicians advantageously use the parenteral forms of ACHROMYCIN in establishing immediate, effecti antibiotic concentrations. With ACHROMYCIN you can expect prompt

TRAMUSCULAR Used to start a pa-
ent on his regimen immediately,
for patients unable to take oral
dication. Convenient, easy-to-use,
leally suited for administration
office or patient's home. Supplied
single dose vials of 100 mg., (no
frigeration required).

MYCIN*

Hydrochloride
Tetracycline HCl *Lederle*

N MINUTES -- SUSTAINED FOR HOURS

ontrol, with minimal side effects,
ver a wide variety of infections -
easons why ACHROMYCIN is one of to-
ay's foremost antibiotics.

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just one specific therapeutic purpose

to curb the appetite of the overweight patient



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(brand of phenmetrazine hydrochloride)

PRELUDIN makes reducing:

Effective because it provides potent appetite suppression, while minimizing the undesirable effects on the central nervous system which may be encountered with certain other weight-reducing agents.[1]

Comfortable because it virtually eliminates nervous tension, palpitations and loss of sleep.[2]

Notably safe because it is not likely to aggravate coexisting conditions, such as diabetes, hypertension or chronic cardiac disease.[3]

References: (1) Holt, J. O. S., Jr.: Dallas M. J. 42:497, 1956. (2) Gelvin, E. P.; McGavack, T. H., and Kenigsberg, S.: Am. J. Digest. Dis. 1:155, 1956. (3) Natenshon, A. L.: Am. Pract. & Digest Treat. 7:1456, 1956.

PRELUDIN® (brand of phenmetrazine hydrochloride). Scored, square, pink tablets of 25 mg. Under license from C. H. Boehringer Sohn, Ingelheim.

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safe...for your little patients, too

"a definite relaxant effect"[1]

With NOSTYN "...almost without exception the children responded by becoming more amenable, quieter and less restless."[1]

without depression, drowsiness, motor incoordination

"The most striking feature is that this drug does not act as a hypnotic...."[1] "No toxic side-effects were noted, with particular attention being paid to the hematopoietic system."[2]

dosage: *Children:* 150 mg. (½ tablet) three or four times daily. *Adults:* 150-300 mg. (½ to 1 tablet) three or four times daily.

supplied: 300 mg. scored tablets, bottles of 48 and 500.

(1) Asung, C. L.; Charcowa, A. I., and Villa, A. P.: Sea View Hosp. Bull. *16*:80, 1956. (2) Asung, C. L.; Charcowa, A. I., and Villa, A. P.: New York J. Med. *57*:1911 (June 1) 1957. (3) Report on Field Screening of Nostyn by 99 Physicians in 1,000 Patients, June, 1956.

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calmative **nostyn**®

Ectylurea, AMES
(2-ethyl-*cis*-crotonylurea)

"of value in the hyperactive as well as the emotionally unstable child"[3]



New Chemotherapy

ARALEN® *in* RHEUMATOID ARTHRITIS

Extensive studies of rheumatoid arthritis and related collagen diseases—in this country and abroad—have shown the antimalarial Aralen phosphate to be highly effective and well tolerated in a large percentage of patients.

Clinical Results with Aralen in Rheumatoid Arthritis

Author	No. of Cases	Major Improvement	Minor Improvement	No Effect
Haydu[1]	28	22	5	1
Rinehart[2]	25	12	4	9
Freedman[3]	50	43	3	4
Bagnall[4]	108	77	12	19
Bruckner[5]	36	32	0	4
Cohen and Calkins[6]	22	17	3	2
Scherbel et al.[7]	25	9	8	8
Total	294	212 (72%)	35 (12%)	47 (16%)

- Success dependent upon persistent treatment
- Often of benefit where other agents have failed
- Remissions on therapy well maintained
- Remission of 3 to 12 months possible even if treatment is interrupted
- Tachyphylaxis not evident

GENERAL EFFECTS:

- Patient feels better
- Patient looks better
- Exercise tolerance increases
- Walking speed and hand grip improves

LABORATORY EFFECTS:

- E. S. R. may fall slowly
- Hemoglobin level may gradually rise

ANALGESICS AND STEROIDS:

- Requirements usually reduced or eliminated

JOINT EFFECTS:

- Pain and tenderness relieved
- Mobility increases
- Swellings diminish or disappear
- Muscle strength improves
- Rheumatic nodules may disappear
- Even severe or advanced deformity may improve
- *Active* inflammatory process usually subsides
- Joint effusion may diminish

DOSAGE:

Aralen is cumulative in action and requires four to twelve weeks of administration before therapeutic effect become apparent.

Latest information indicates that an initial dose of 250 mg. of Aralen phosphate is preferable to the higher doses sometimes recommended. However If side effects appear, withdraw Aralen for several days until they subside. Reinstate treatment with 125 mg. daily and, if well tolerated, increase to 250 mg. The usual maintenance dose is 250 mg. daily.

New Chemotherapy

INDICATIONS:

- Rheumatoid arthritis, acute or chronic —with or without adjunctive therapy.
- Spondylitis
- Arthritis associated with lupus erythematosus or psoriasis

THEORY OF ACTION:

Aralen appears to suppress or induce remission of rheumatoid inflammatory processes by inhibiting adenosinetriphosphatase.

HOW SUPPLIED:

Aralen phosphate: 250 mg. tablets in bottles of 100 and 1000.
125 mg. tablets in bottles of 100.

Tolerance:

Aralen is usually well tolerated. Toxic effects are usually mild and to date have been transitory in nature, disappearing completely either on continuance or cessation of therapy or on reduction in dosage.

Gastrointestinal disturbances (e.g. nausea, rarely vomiting, diarrhea, abdominal cramps, anorexia) are frequent manifestations of intolerance. Temporary blurring of vision (due to interference with accommodation) is also relatively frequent.

Pleomorphic skin eruptions (e.g. lichenoid, maculopapular, purpuric), although generally mild, may preclude the use of an optimum dosage schedule. If a skin reaction persists on a reduced dosage schedule, or recurs after reinstitution of treatment with gradually increasing doses, discontinue Aralen till the lesion again disappears and consider resuming treatment with Plaquenil® (brand of hydroxychloroquine).

Less frequently transitory vertigo, headache, lassitude, or neurological disturbances, such as nervousness, irritability, emotional change, and nightmares have been reported. Instances of unexplained slight gradual weight loss as the patient's general health and arthritic condition improved have been mentioned. Occasional instances of bleaching (depigmentation) of the hair have been described.

Although an occasional instance of leukopenia, with normal differential count, has been reported (WBC about 3000), it has not proved troublesome because it has always been reversible on discontinuance, or diminution of the dose. Even spontaneous reversal may occur while full dosage is maintained.

Caution:

Aralen is known to concentrate in the liver and, although hepatic damage has never been reported, the drug should be used with caution in the presence of liver disease. In the presence of severe gastrointestinal, neurological, or blood disorders, the drug should be used with caution or not at all. If such disorders occur during the course of therapy, the drug should be discontinued. Concomitant use of gold or phenylbutazone with Aralen should be avoided because of the tendency of these agents to produce drug dermatitis.

Clinical Comments:

Of fifty patients receiving Aralen therapy, "43 have become really well; that is, they have no stiffness, and any pain that occurs can reasonably be attributed to use of joints affected by secondary degenerative changes. They have no evidence of joint inflammation, but may have a raised erythrocyte sedimentation rate. They have little or no need for analgesics." *Freedman*[3]

"One hundred and twenty-five private patients have been carefully followed clinically and haematologically while receiving well over 200 patient-years of chloroquine [Aralen] therapy. The results are considered good in 70%, one-half of these cases being in remission. Improved work performance, sedimentation rate, and hemoglobin levels paralleled the major objective gain in this 70%. 90% of them remained on chloroquine [Aralen] therapy, half for more than two years. Classical peripheral rheumatoid arthritis, spondylitis, arthritis of juvenile onset, and rheumatoid disease with psoriasis, all appeared to respond about equally well.

"It is suggested that chloroquine comes closer to the ideal for long-term, safe, control of rheumatoid disease than any other agent now available." *Bagnall*[4]

"Out of the 36 rheumatoid arthritis cases we treated . . . favorable results were obtained in 32 cases. *Bruckner et al.*[5]

References

1. Haydu, G.G.: Rheumatoid arthritis therapy: a rationale and the use of chloroquine diphosphate, *Am. J. M. Sc.* 225:71, Jan., 1953.
2. Rinehart, R.E.: Chloroquine therapy in rheumatoid arthritis, *Northwest Med.* 54:713, July, 1955.
3. Freedman, A.: Chloroquine and rheumatoid arthritis, a short-term controlled trial, *Ann. Rheum. Dis.* 15:251, Sept., 1956.
4. Bagnall, A.W.: The value of chloroquine in rheumatoid disease, a four year study of continuous therapy, read at the Ninth International Congress on Rheumatic Diseases in Toronto, Canada, June 23-28, 1957.
5. Bruckner L., and Rosenzweig, S.: Treatment of chronic rheumatoid arthritis with synthetic antimalarials, read at the Ninth International Congress on Rheumatic Diseases in Toronto, Canada, June 23-28, 1957.
6. Cohen, A.S., and Calkins, Evan: A controlled study of chloroquine as an antirheumatic agent, read at the Ninth International Congress on Rheumatic Diseases in Toronto, Canada, June 23-28, 1957.
7. Scherbel, A. L., Schuchter, S.L., and Harrison, J.W.: Comparison of effects of two antimalarial agents, hydroxychloroquine sulfate and chloroquine phosphate, in patients with rheumatoid arthritis, *Cleveland Clin. Quart.* 24:98, April, 1957.

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For—
quick symptomatic relief
or prophylaxis in
urinary tract infections

NEW

SUROMATE

TRADEMARK

patch

THE TRIPLE SULFA

Sulfadiazine	100 mg.
Sulfamerazine	100 mg.
Sulfacetamide	100 mg.

An *improved* combination including sulfacetamide . . . efficient antibacterial of exceptional solubility.[1] Offers wide-spectrum activity with low dosage, minimal danger of crystalluria or sensitization.[2] Preferred to antibiotics because drug resistance or superinfection is less likely.[3]

with the DOUBLE PLUS...

+ Ext. Hyoscyamus (alkaloids 0.155%) .	5.75 mg.
+ Potassium Citrate .	200 mg.

Antispasmodic action of hyoscyamus quickly relieves pain, irritation, burning, urgency.[4]

Alkalizing and diuretic effects of potassium citrate enhance sulfonamide solubility and safety.[4]

Supplied: Bottles of 100 tablets.

1. Kerley, L., and Headlee, C. P.: J. Am. Pharm. A. (Scient. Ed.) 45:82, 1956. 2. Lehr, D.: Special Exhibit, Mod. Med. 23:111, No. 2, 1955. 3. Editorial, J.A.M.A. 160:210, 1956. 4. Bastedo, W. A.: Materia Medica, Pharmacology, Therapeutics and Prescription Writing, ed. 4, Philadelphia, W. B. Saunders Company, 1937, pp. 514, 101.

patch

THE E. L. PATCH COMPANY
STONEHAM, MASSACHUSETTS

CORN OIL is a Prime Source of UNsaturated Fatty Acid

Numerous clinical studies emphasize its efficacy in the reduction and control of serum cholesterol levels





Physicians are quite aware of the rapidly growing appreciation of the role of dietary lipids in health and disease. Accumulating metabolic studies throughout the world indicate that serum cholesterol levels may be influenced more by the *kind* than by the *amount* of the dietary fat.

Unsaturated fats tend to depress serum cholesterol levels in many patients, whereas saturated fats may have the opposite effect. Medical references on this subject, as well as other findings concerning unsaturated fatty acids in nutrition, may be found in the book, "Vegetable Oils in Nutrition."

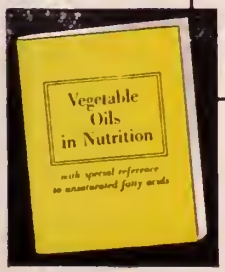
Mazola Corn Oil is an excellent source of *un*saturated fatty acids...85% of its component fatty acids are unsaturated...average values being 55% linoleic acid, 30% oleic acid. Mazola is unadulterated corn oil in its natural form...*not* flavored, *not* blended, *not* hydrogenated. Well tolerated, easily digested, readily absorbed, Mazola is also an excellent carrier for fat soluble vitamins.

Mazola Corn Oil is widely used for salad dressings, in frying, cooking and baking... and thus may be included palatably in great variety as a replacement for part of the daily fat intake.

COMPARATIVE COMPOSITIONS OF FOOD FATS AND OILS

Fat	Fatty Acids as Percentage of Total Acids									Iodine Value	
	Saturated		Oleic		Linoleic		Linolenic		Arachidonic		
	Ave.	Range	Ave.	Range	Ave.	Range	Ave.	Range	Ave.	Average	Range
Butter	—	46-48	—	—	4.0	—	1.2	—	0.2	—	26-42
Coconut oil	—	75-88	—	5-8	—	1.0-2.5	—	—	—	—	7-10
Corn oil	13	11-15	—	23-40	56	46-66	—	0.0-0.6	—	126	113-131
Cottonseed oil	26	21-30	27	22-36	47	34-57	—	—	—	105	90-117
Lard	43	—	46	—	10	15.6	0.5	—	0.5 (2.1)	—	53-77
Linseed oil	—	6-12	—	13-31	—	10-27	—	30-64	—	—	170-204
Margarine	23	15-23	62	59-77	5.8	5-11	—	0.1-0.9	0	81	74-85
Olive oil	—	8-16	—	53-86	—	4-20	—	—	—	—	80-88
Peanut oil	17	14-22	54	44-65	29	20-37	—	—	—	98	90-102
Shortening	25	17-45	62	43-79	5	3-12	—	0.2-0.6	0-0.5	78	59-80
Soybean oil	15	11-18	25	18-58	55	28-62	5.1	0.3-10	—	130	100-143
Tallow (beef)	53	—	42	—	4	5.3	0.5	—	0.5	—	40-48

Iodine numbers are an accepted measure of the degree of unsaturation of vegetable oils.



TO PHYSICIANS interested in the study and management of high cholesterol blood levels, this most recent monograph will provide helpful information. It is free on request. Write to: Corn Products Refining Company, 17 Battery Place, New York 4, N. Y.

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If you could visit with a user of the Picker Anatomatic Century x-ray unit you'd soon know why this remarkable "new way in x-ray" machine has come so far so fast.



He'd probably tell you first how incredibly easy it is to use (just dial the body part and set its thickness... then press the button). He might sigh with relief at having no charts to consult, no calculations to make (the anatomatic principle does all the tedious "figgerin" for you).



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He might even touch on the peace-of-mind that comes of having a local Picker office so near, with a trained Picker expert always on call for help and counsel

and there'd be no mistaking the light in his eye when it falls on the handsome big-name unit whose fine appearance adds so much to the impressiveness of his office.



P.S. Somewhere along the line the matter of price would come up ... he'd most likely comment on how little he paid to get so much. Or he might even be among those who rent their x-ray machine (Picker has an attractive rental plan, you know).

P.P.S. Next best thing is to call your local Picker man in and let him tell you about this great new machine (find him in your 'phone book) or write Picker X-Ray Corporation, 25 South Broadway, White Plains, N. Y.

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In keeping with its tradition of responding to the immediate needs of the medical profession, Lederle announces the availability of "Influenza Virus Vaccine-Monovalent, Type A Asian Strain," produced according to N.I.H. specifications.

The vaccine is specific against the known strains of the so-called "Far East Influenza" virus, and is supplied in a 10 immunization (10 cc.) vial. Every effort will be made to fulfill your requirements.

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QUADRACINE®*

Clinically Proved to Promote Ulcer Healing

- Without dietary restrictions.
- With a significant reduction in rate of recurrence and incidence of complications.
- With alleviation of patient's anxiety and threat to Security.
- Without patient resistance or confusion.

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℞ 2 Tablets Q.I.D., after meals; 1 after eating, 1 an hour later.

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*Pat. Pending

REFERENCES: 1. Field, H., Robinson, W. D. and Melnick, D: Ann. Int. Med. 14:588, 1940. 2. Rosenblum, L. A., and Jolitte, N.: J.A.M.A. 117:2245, 1941. 3. Manuscript in preparation for publication. 4. Manuscript in preparation for publication. 5. Council on Pharmacy and Chemistry: J.A.M.A. 159:1291 (Nov.) 1955.6. Chapman, W. P., Wyman, S. M., et al: Gastroenterology 28:500,510,531 (April) 1955.

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minor chemical changes can mean major therapeutic improvements

Medrol*

The most efficient of all anti-inflammatory steroids

- Lower dosage (⅓ lower dosage than prednisolone)
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Supplied: Tablets of 4 mg., in bottles of 30 and 100.

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SQUIBB IRON, B COMPLEX AND B_{12} VITAMINS ELIXIR

- to correct many common anemias
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- to aid in promotion of growth and stimulation of appetite in poorly nourished children

Each teaspoonful (5 cc.) supplies:

Elemental Iron (as ferric ammonium citrate and colloidal iron) (equivalent to 130 mg. ferrous sulfate exsiccated)	38 mg.
Vitamin B_{12} activity concentrate	4 mcg.
Thiamine mononitrate	1.0 mg.
Riboflavin	1.0 mg.
Niacinamide	5 mg.
Pantothenic acid (Panthenol)	1.5 mg.
Pyridoxine hydrochloride	0.5 mg.

Alcohol content: 12 per cent

Dosage: 1 or 2 teaspoonfuls t.i.d.

Supply: Bottles of 8 ounces and 1 pint.

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"RUBRATON" ® IS A SQUIBB TRADEMARK

MAJOR ADVANCE IN FEMALE HORMONE THERAPY

for certain disorders of menstruation and pregnancy

With NORLUTIN you can now prescribe truly effective *oral* progestational therapy. Small oral doses of this new and distinctive progestogen produce the biologic effects of injected progesterone.

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Presecretory to secretory endometrium after 5 days' treatment with NORLUTIN.



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The x-ray diffraction pattern of NORLUTIN distinguishes its crystal structure from that of other progestogens.

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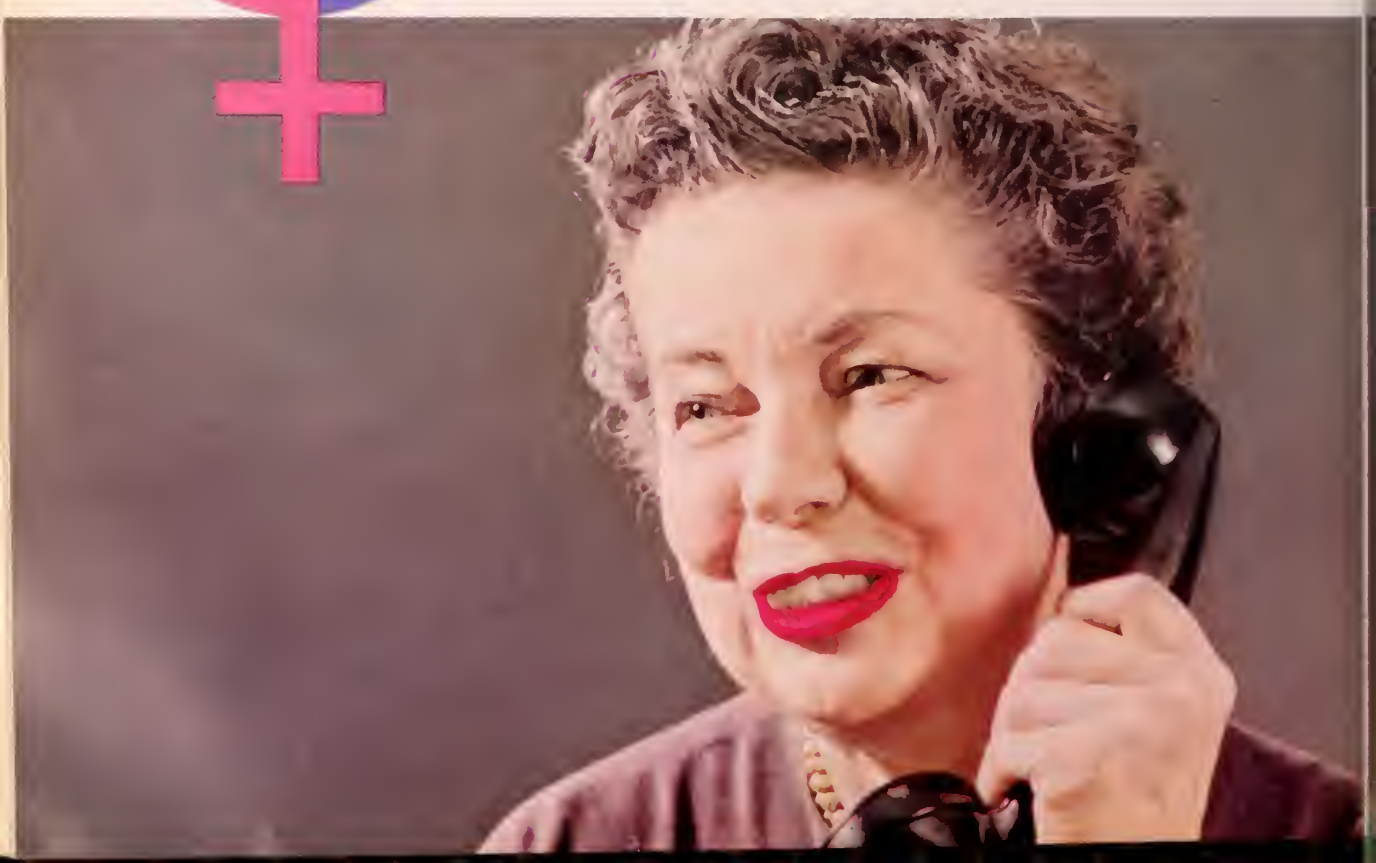
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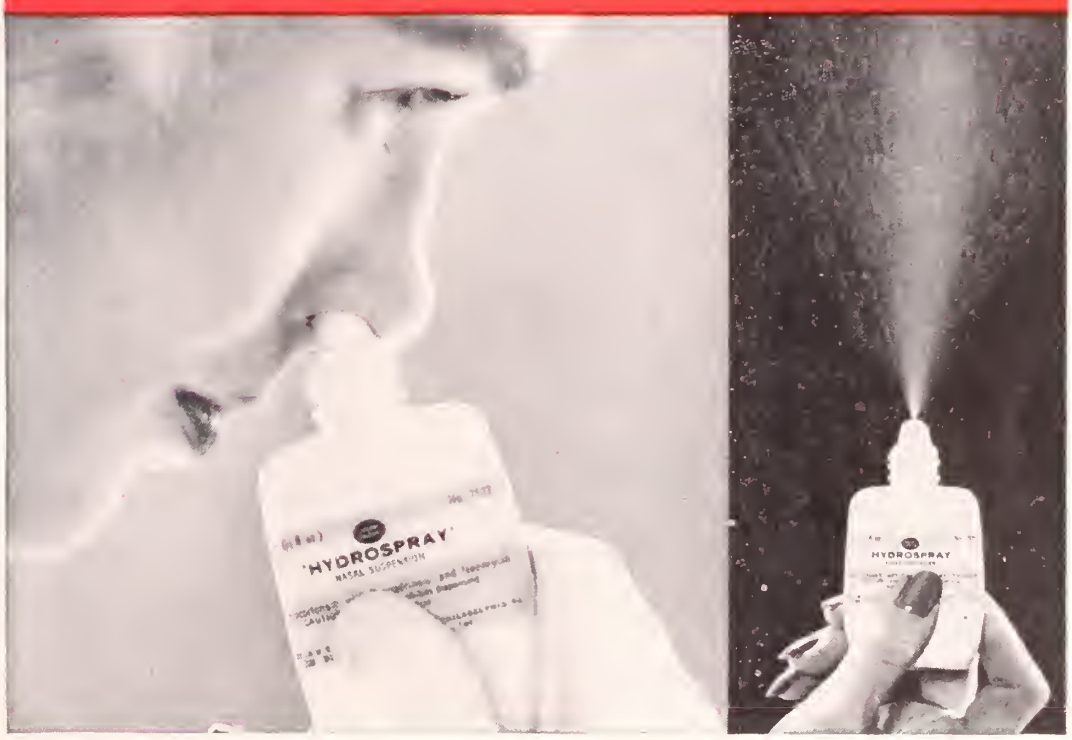


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REFERENCE: 1. Silcox, L. E., *A.M.A. Arch. Otolaryng.* 60:431, Oct. 1954.

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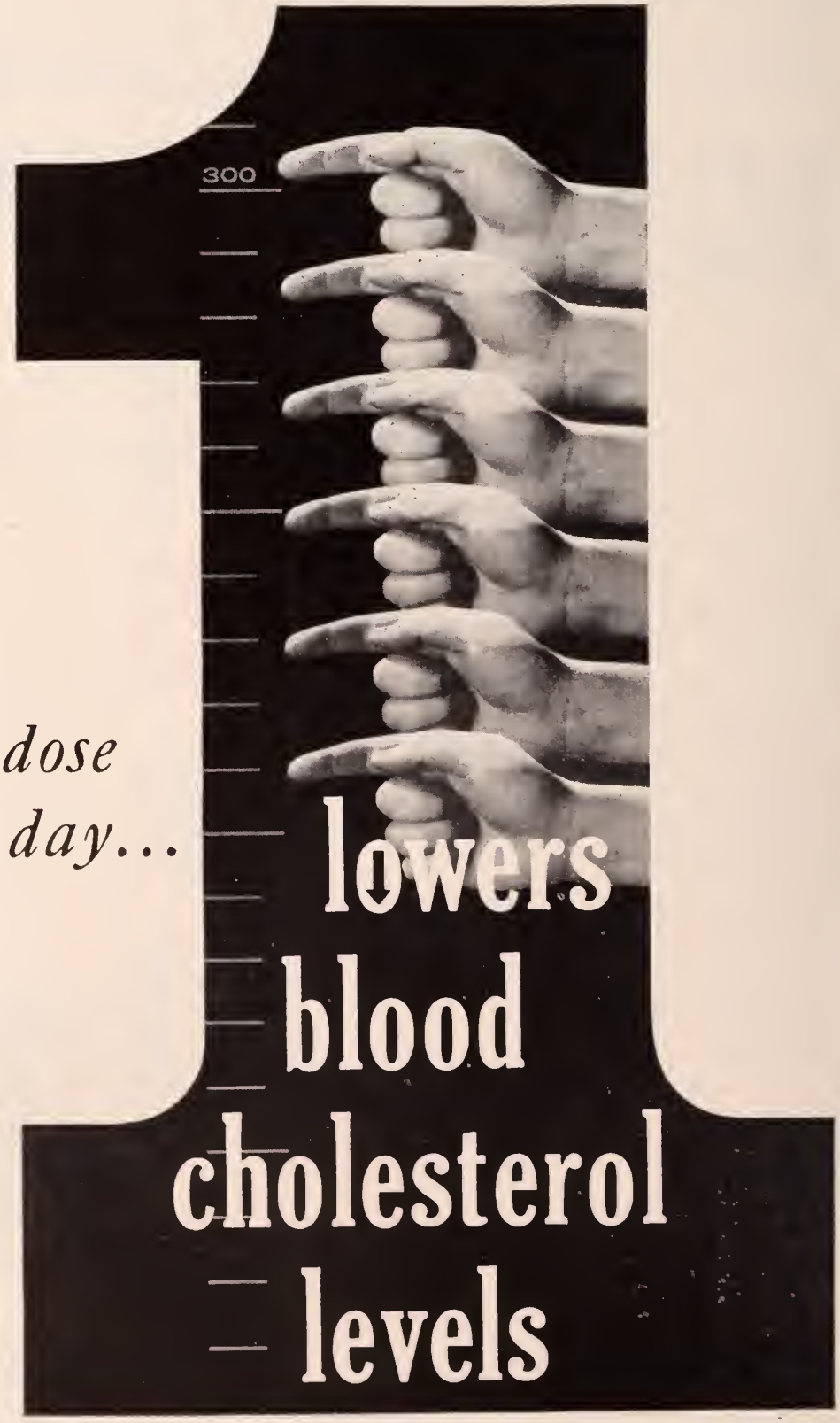
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Urticaria and angioneurotic edema	3	1	1	1		Dizzy (1)
Allergic dermatitis	2		1	1		Slight Drowsiness (2)
Bronchial asthma	1		1			
Pruritus	1		1			
Total	37	15	13	7	2	Drowsiness (5) Dizzy (1) 16.2%

» unexcelled antihistaminic action

From the preliminary **Dimetane Extentabs** studies of three investigators. Further clinical investigations will be reported as complete



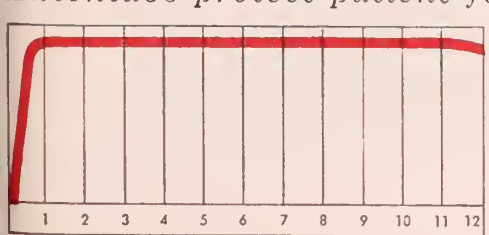
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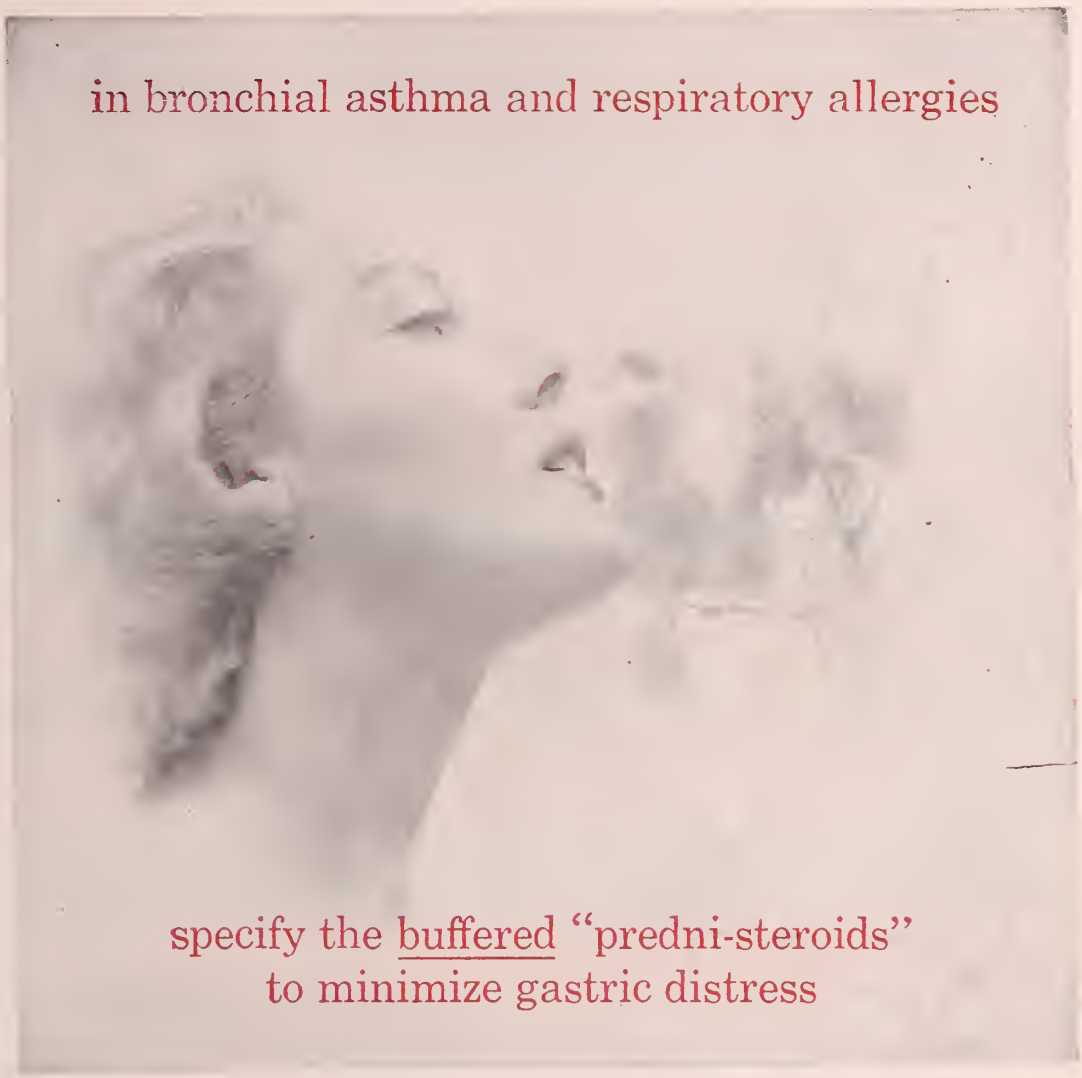
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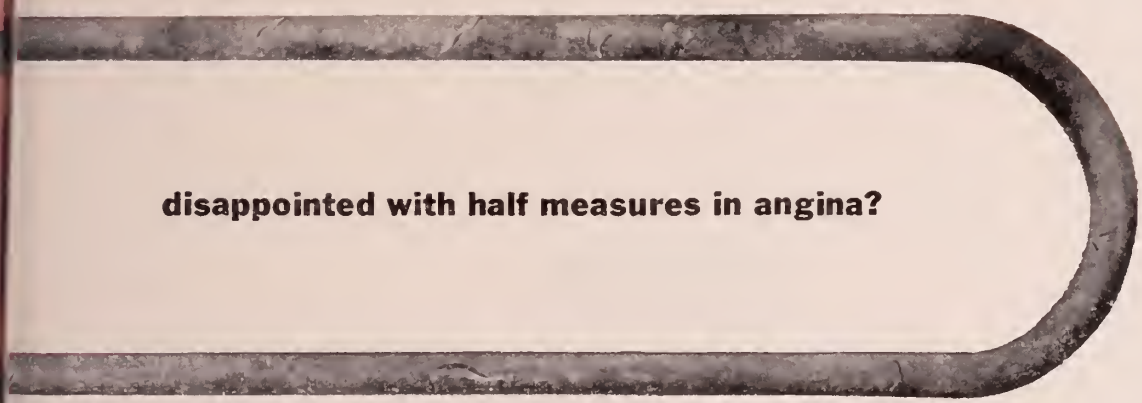
CARTRAX should be taken *before* meals, on a *continuous* dosage schedule. Use with caution in glaucoma.

1. Russek, H. I.: J. Am. Geriat. Soc. *4*:877 (Sept.) 1956.

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THE JOURNAL
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Editorials • • •

Research: Basic, Clinical and Applied

Clinical research gets the headlines. Here for all to read is human drama — Pasteur saving the children from hydrophobia; sulfa drugs curing a previously fatal disease; a miracle of surgery to repair a congenital heart defect. And since the aim of medical research is to prolong life, what better way than to see if proposed methods *do* prolong life?

By contrast, basic research is tainted with the odor of "theory." The pH of the blood of the parrot—who cares? the logarithmic helix which describes the segmental growth of an earthworm—sheer mathematics! The reproduction of fruit flies? Surely that's of enchanting interest only to other fruit flies. And so the sneer at theory continues. Indeed, when told that cigarette smoke produces malignant tumors in mice, some scoffers have been heard to utter "this proves only that mice shouldn't smoke"—thus denying (because they wished to deny) any human inference from such studies.

And yet, in the long run, it is basic research, if anything, which will save us. Cancer is growth gone crazy, and whatever contributes to an understanding of growth, whether in sea urchins or slime molds, contributes to our understanding of cancer. The building block of life is protoplasm, a dimly understood chemical that has many secrets to yield to the physicist, biologist and chemist, long before this knowledge can be utilized by the medical practitioner. There are but two neurones in the long trail from the motor cortex to the Babinski-reacting toe. A study of the way in which simpler forms of life gear those two neurones together may unlock the secrets of the synapse, which in turn, is basic to our understanding of the physiology of the nervous system. An electric brain is a poor imitation of your brain or mine. Yet an understanding of the mathematics and electronics of cybernetics may reveal something of the mechanics of thought. The number 1 killer — cardiovascular disease—has been studied by clinical methods until, so to speak, the experimenters are blue in the face. But we will

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never understand it until we understand more about cholesterol metabolism, the physics of the heart beat, the chemistry of colloids, and the whole biologic subsoil in which cardiovascular activity is rooted.

And arthritis, the great disabler—and multiple sclerosis—and the dystrophies and atrophies, what know we of them? In vain our best microscopes and microscopists have been focused on these diseases. In vain we have run through a cornucopia of pharmaceuticals testing whether this one or that one will cure. For these diseases are but superstructure. The foundation is something in human biology, something requiring the joint understanding of the biologist, the biochemist, the physiologist, the physician, the pharmacologist and the physicist.

In this as in much of life, it may be said there is nothing so practical as a sound theory.

Blue Shield's "Lost Generation"

The creators of Blue Shield were determined to prove that medicine could create a prepayment plan that the public would accept. They were fired with an urgent challenge to turn back the threat of socialized medicine.

The labors of some of these pioneers in Blue Shield are legendary. They were flying blind, over unknown and treacherous terrain. They were bucking strong headwinds of popular skepticism, official scorn and professional indifference. Many of these doctors devoted every hour they could spare from their practices to the missionary job of carrying the story of Blue Shield to every county society, every hospital staff meeting—to every place where they could get an audience of two or more doctors to listen to them.

These men created better than they knew. A prepayment movement that ten years ago numbered barely five million subscribers is now providing basic medical care security to forty million people. And the seventy Blue Shield Plans count some 120,000 doctors as "participating physicians."

In the fifteen years that have elapsed since Blue Shield Plans were founded, a whole new generation of doctors have come on the scene. For them, Blue Shield is only a part of the heritage of medicine bequeathed to this generation by those that have gone before.

This new generation knows nothing of the labors and sacrifices of their older colleagues in creating Blue Shield. Our younger brethren take Blue Shield for granted. Some do not even understand the differences between Blue Shield and the commercial insurance companies. Some doctors, noting that prosperity among our patients has helped to assure us of collection of fees, have even thought that prepayment itself may no longer be needed.

A great blanket of complacency has come upon us in recent years. Paradoxically, this complacency—the most serious threat to the future security and progress of Blue Shield—is, in large part, a consequence of Blue Shield's past success.

But the future is not as secure as the past. *Blue Shield is the only segment of America's great health insurance program that has been shaped by our profession and is subject to our control.* The time is past due for a revival of the crusading spirit that created Blue Shield, and is still needed if it is to complete the job it was intended to do for our patients, ourselves and our society.

Lies Can Save Lives

Every doctor knows that, on certain occasions, telling the patient the truth may plunge him into a depression, drain out his will to live, destroy his morale or precipitate a suicide. The phrase "to tell a lie" sounds ugly and sinful. We prefer to evade this by explaining that the issue is not "to tell lies" *vs.* "not to tell lies," but rather one of how much wisdom and discretion to use in explaining an illness. Sometimes it is balder than that. Sometimes the patient asks a blunt question and either the doctor tells a painful truth or a saving—and salving—lie.

The first disease one thinks of in such a context is cancer. You seldom see any great controversy on telling the truth about heart disease, though heart disease kills more people than cancer. The distinction here seems to be semantic rather than medical. We can speak of coronary episodes in the past, implying that they are over—"you had a coronary attack," with the emphasis on the *had*. But cancer is always in the present tense. Yet this need not be so. Cancers have been removed with no recurrence and no metastasis. The number of such permanent cures is increasing every year. Still the *word* remains—not a label but a doom.

Here is a woman with a rodent ulcer of the lip. Is this cancer? Yes, it is. But the prognosis is excellent and what possible good would it do the patient to tell her she has a cancer? The only criterion of a medical action is the patient's welfare. This is not served by pronouncing the words of doom when the chances are the patient will be cured of the malignancy. Tell her that she has cancer, and —no matter how optimistic and casual you are —she will suffer an irreparable emotional trauma, which may lead to anything from depression to suicide. The rodent ulcer used to be called *noli me tangere*. Perhaps today, *noli me dicere* would be better.

But, you say, you have stacked the argument by selecting the one malignancy with a high cure rate. The prognosis from cancer is improving year by year. Cases with a good, or at least a fair, outlook are more common. Also, the number of years of living—not just vegetating, but, if you please, the good life—after diagnosis, can be substantial. Every doctor knows of carcinoma victims who have lived for 3 or 4 years and then died of coronary attacks. A person can (sometimes) live longer with a myelocytic leukemia than with some non-malignant diseases. And every practitioner can name some patients, who, in all logic, should have been dead two or three years ago and who continue to survive — sometimes fairly actively—as if there were some secret well spring of life force somewhere in the body.

The man of affairs should have time to get his affairs in order if death seems likely. This can be tactfully handled by having such a patient reduce his business activities in order to get the necessary prolonged rest, or to accomplish a more tranquil life. It can be put to him on that benign basis. Hope and faith are powerful medicines. Their tonic effects on body metabolism have often fought off disease for many years. Death always wins in the end, of course. But our job as doctors is not to defeat death—none can do that—but simply to postpone his visit. And here faith, hope, reassurance and tranquility are our allies. On the other hand, death is hastened by fear, demoralization and hopelessness. It is a sin to tell a lie; but a man does not practice medicine simply to save his own soul. He has a sworn duty to help his patients. So if the lie will save lives, let it be told. Human life is so important in the eyes of God, that surely He will forgive so venial a sin for so precious a purpose.

Original Articles • • •

WILLIAM GREIFINGER, M.D.

Newark

Action and Reaction*

A PROFILE OF THE NEWER DRUGS

The new wonderland of pharmacy has enchanted many of us with the actions of the new drugs. But, as Dr. Greifinger so well reminds us here, to every action there is also a reaction. The wise practitioner knows these as well as he knows the desired and desirable effects.

More than 80 per cent of the pharmacologic agents now available were completely unknown ten years ago. The practitioner now has at his disposal more than 140,000 *different* preparations. No doctor could ever hope to hack his way through this pharmaceutical jungle were it not for the fact that only a few hundred of these are needed for the treatment of the common disorders.

While drugs, particularly the newer ones, may literally save lives and prevent disability, it must also be remembered that they may have adverse effects, too. Brown[1] has classified such reactions as follows:

1. *Toxic*—Harmful or poisonous reactions may be exaggeration of known pharmacologic action. This is not an allergic problem. A drug may be primarily toxic if its usual action is a poisonous one or secondarily toxic if a therapeutic dose causes true toxic symptoms.

2. *Side Effects*—These are undesirable, non-toxic, non-allergic effects such as the mental depression of reserpine or the somnolence of the antihistamines.

3. *Idiosyncrasy* — A qualitative abnormal reaction such as excitement that sometimes follows barbiturates.

4. *Intolerance*—This is a quantitative deviation from the normal such as the excessive salivation following small dosages of iodides or the cinchonism from small doses of quinine. The reactions are similar to pharmacologic overdosage although they may result from the usual dosage of medication.

5. *Secondary Effects*—Indirect reactions caused by drugs. For example, the vitamin deficiency due to the effect of anti-microbial agents on the intestinal bacteria.

6. *The Schwartzman Phenomenon* — This special type of inter-relation between a drug and a previous infection, may explain hemorrhagic cutaneous reactions.

7. *The Jarisch-Herxheimer Reaction*—This is due to the immediate direct effect on the body of the toxins released by bacteria that the drug has affected. The drug causes exacerbation of existing lesions or development of new ones because it destroys the organisms too vigorously.

8. *Drug Allergy or Hypersensitivity*—This term should be reserved for the unusual but

*Read before the Allergy Section of The Medical Society of New Jersey, Atlantic City, April 30, 1957.

1. Brown, Ethan Allen: GP 13:92 (March, 1956)

characteristic reaction following the administration of a medicinal substance. The diagnostic criteria of drug hypersensitivity are listed by Alexander [2] as follows:

(a) The recognition of symptoms or lesions which conform to a pattern of drug hypersensitivity. The patterns are not numerous, and are therefore recognized without difficulty. (Skin allergy, asthma, or rhinitis).

(b) A positive history of exposure to a drug. Removal of the drug is followed by clearing of the lesion.

(c) After the lesion has disappeared by omission of the drug, re-administration of it will reproduce the reaction.

If the allergic reaction is due to first exposure of a drug, the original sensitizing administration may never be uncovered. One apparent reason is the phenomenon of *cross-sensitization*. This occurs, for example, with drugs such as the tetracyclines. Another reason is that patients are not aware of what has been prescribed or what may have been taken inadvertently. The latter was demonstrated recently in a patient of mine who is aspirin sensitive. He took Coricidin® without asking about its composition. It took hours of concentrated therapy with epinephrine and injected antihistamines to undo the damage caused by one small tablet.

The allergic reaction may manifest itself in various ways. The most severe immediate complication resulting from any drug is *acute anaphylactoid shock*. It is characterized by severe itching, cyanosis, weakness, dizziness, prostration, drop in blood pressure, respiratory collapse and occasionally death.

Although serum sickness is not as prevalent as it once was, a similar type of delayed reaction is brought about by hypersensitivity to drugs. Clinical manifestations resembling serum sickness are caused by a union between the tissue component and the drug as an aftermath to sensitization.

The skin is the most common site of drug reactions. The principal types of dermatologic manifestations are:

1. Allergic eczematous dermatitis, contact type.
2. Urticaria.
3. Exanthematic eruptions.
4. Exfoliative dermatitis.
5. Bullous eruptions.
6. Purpura simplex.
7. Fixed eruptions.

The second most common allergic reaction to drugs is the systemic lesion which includes the shock pattern, the serum sickness pattern, both of which have already been referred to, and the blood dyscrasias. All elements of the blood may be depressed by certain drugs. The white blood cells can be selectively depressed by the thiouracils, Butazolidin®, some of the antihistamines and the chloramphenicols. Where there is leukopenia, a history of taking any one of these may help in pinpointing a diagnosis.

Red blood cells may be depressed by the sulfanilamides or acetanilids. The platelets in the blood or bone marrow may be depressed by quinidine or Sedormid®. Some drugs such as amphetamine, Butazolidin®, and hydralazine may depress all of the bone marrow elements.

The newer drugs are so numerous and their effects so varied that it is impossible to develop a classification that will satisfy everybody. I focus below on three categories only: tranquilizers, antibiotics and steroids. These groups of drugs have been used in treatment of many conditions including diseases of allergy.

TRANQUILIZERS

IN THIS high tension world the quest for tranquility is constant and demanding. The pharmaceutical industry has developed a host of drugs aimed at producing peace of mind. Although no one knows exactly where these medications act, the presumption is that a *sedative* blankets the cortex of the brain, while a *tranquilizer* acts on "lower" centers. So, in theory, the sedative (barbiturates and bromides for example) make the patient sleepy or depressed, whereas the tranquilizer leaves his cortex unaffected, and thus permits him to remain in normal contact with the outside world. Pharmacologists are not sure that this

2. Alexander, Harry L.: Toxic Reactions to Drug Therapy (Philadelphia, Pa., 1955) Saunders Co. page 1.

is true, but the current upsurge of interest in tranquilizers is based on this assumption. Krantz and Truitt [3] classify tranquilizers under four headings: the rauwolfia alkaloids, the phenothiazines, the propanediol dicarbamates and the diphenyl methanes. Thus, reserpine is a rauwolfia alkaloid, chlorpromazine is a phenothiazine, meprobamate is a dicarbamate and azacylconot is a diphenyl methane. These terms are more easily recognizable under their trade names of Serpasil®, Thorazine®, Miltown®, and Frenquel® respectively.

Rauwolfia Alkaloids — Rauwolfia is available for oral administration as whole powdered root, as partly purified mixtures and as the single alkaloid reserpine. They are antihypertensive and mood ameliorating agents. They are especially valuable in psychiatric and neurologic disorders but have also been used in dermatologic and allergic conditions. The Food and Drug Administration recently warned that the total daily dose of reserpine should not exceed 0.25 milligrams. This low dosage presumably prevents the ill effects described for this drug. From personal experience, I know that this is too small a dose to lower the blood pressure or achieve much tranquility. In my opinion it is safe to give doses of 0.25 milligrams 2 to 3 times per day for several weeks; then, decrease to 0.1 milligrams twice daily.

Many adverse effects have been recorded such as nasal stuffiness, drowsiness, hypotension, dermatitis, mental depression, facial edema and parkinsonism. The edema and the dermatitis are both helped by the antihistamines. Selenium sulfide has been effective in checking seborrheic dermatitis. The nasal stuffiness is relieved by decongestants. Drowsiness and hypotension may be benefitted by psychomotor stimulants. This kind of parkinsonism can be cured by discontinuance of the drugs. If continuation of the drug is desirable then Cogentin® or Artane® may be prescribed.

Non-allergic complications include menstrual irregularities, convulsions, hallucinations, and nightmares.

3. Krantz, John C. and Truitt, Edward B.: Modern Medicine 25:75 (January, 1957)

Chlorpromazine—Under the trade name, Thorazine®, this was originally used solely as an antihistamine. Later it was found to have a tranquilizing effect. Today, antihistamine effect is over-shadowed by its strong central sedation. Its action is immediate and therefore useful in combating acute anxiety syndromes. This tranquilizer should *not* be given in conjunction with barbiturates or opiates because together they may produce serious coma.

Although chlorpromazine is useful in some psychiatric disorders, it must be given with caution as serious reactions may occur. Chlorpromazine should not be prescribed indiscriminately for psychosomatic symptoms or allergies of a psychosomatic nature. Some of the side reactions are due to autonomic nervous system disturbances. These include dryness of the mouth, nasal congestion and contraction of the pupils. The hypotensive effect is of the postural type and is aided by norepinephrine. The nasal congestion is relieved by vasoconstrictors.

The skin reactions which may occur are allergic in nature manifesting themselves as urticaria or contact dermatitis, both of which cause severe itching. The pruritus is relieved by the antihistamines. Photosensitivity complicates the skin rash and avoidance of exposure to the summer sun is advisable.

Retention jaundice and parkinsonism have occurred frequently enough to warrant close observation of patients on this drug. Fortunately, discontinuance of the medication results in eventual recovery. Cortisone therapy hastens the clearance of the intra-hepatic obstructive jaundice. Another severe reaction is agranulocytosis which responds well to withdrawal of the drug.

Promazine — Generally known under its trade name, Sparine® this is less potent than chlorpromazine, less toxic, and less likely to provoke an allergic skin reaction. There have been several reports of agranulocytosis. I have found promazine valuable in both acute anxiety states and in delirium tremens. For maximum effect, it is administered intravenously or intramuscularly.

Meprobamate—Here is one of the most

widely prescribed pharmaceuticals in America. Under its trade names Miltown® and Equanil®, it is dispensed daily in almost every retail pharmacy in the land. In my hands, it has been effective in diminishing the frequency of asthmatic attacks if the attacks have a strong emotional component. The drug is the dicarbamic ester of propanediol compound, related to mephenesin. This relationship may account for the anaphylactoid type of reaction which has been reported in some individuals after the ingestion of a single tablet.

Meprobamate depresses the synapses within the reflex chains in the brain stem and spinal cord. Adverse reactions are being reported with increasing frequency. Many of these untoward reactions are truly allergic.

Shane and Hirsch[4] have noted coma, marked muscle relaxation with absent reflexes, and a dangerous fall in blood pressure. They also warn about a suicide impulse which the drug possibly leads to in some borderline psychotics. Friedman and Marmelzat[5] report three cases of paradoxical excitement, one of intestinal hyperperistalsis and a case of eye muscle paralysis, apparently precipitated by meprobamate. Five of their patients also developed purpura and severe pruritus.

Treatment for the allergic type of reaction consists of discontinuance of the medication then the use of antihistamines, epinephrine or even the steroids. Recovery follows promptly.

ANTIBIOTICS

SULFONAMIDE therapy today may be grouped into two technics. One involves the sulfonamide combinations; and the other depends on sulfisoxazole.

The newer sulfa drugs have greatly reduced the incidence of untoward reactions. Blood dyscrasias have been reduced to 0.1 per cent and renal tubular blockage has practically been eliminated as a complication of these drugs.

Superimposed infections which may occur (especially with the more versatile antibiotics) are rare with sulfonamide therapy. The sulfa drugs can prevent hemolytic streptococcus infections but they do not eradicate streptococci once they have invaded the tissues; consequently they do not prevent the non-suppurative complications of Group A hemolytic streptococcal infections, rheumatic fever and glomerulonephritis.

Side reactions of the newer sulfonamides have not been numerous. A sensitive person may develop drug fever, rash, urticaria, hematuria, albuminuria or, occasionally, even some mental depression. A few instances of blood dyscrasias have been reported.

Penicillin is the most widely used antibiotic in the world and is also the most allergenic. Each year, a larger number and variety of penicillin reactions are reported, ranging from mild urticaria to the dreaded anaphylactoid shock. At least 100 to 200 severe anaphylactoid penicillin reactions are recorded every year and many are fatal. Repeated exposure accounts for the large number of persons who are becoming sensitized to penicillin.

Berger and Eisen[6] tested 1000 allergic, nonallergic and penicillin sensitive individuals with procaine penicillin using scratch, intradermal and patch tests and concluded that none of these tests was reliable in determining penicillin sensitivity.

Penicillin-V (phenoxymethyl penicillin) is a new kind of penicillin which is acid-resistant and consequently passes through the stomach unchanged. It dissolves in the alkaline medium of the small intestine and produces higher levels in the blood than penicillin G although the antibacterial effect of both are the same.

Side reactions may occur, such as gastrointestinal irritation, abdominal cramping, aphthous stomatitis and urticaria.

Streptomycin has revolutionized the treatment of tuberculosis. Resistance to streptomycin develops frequently but can be minimized by the simultaneous administration of

4. Shane, Aubrey M. and Hirsch, Solomon: Canadian M. J. 74:908 (June, 1956)

5. Friedman, Henry T. and Marmelzat, Willard: Journal of the American Medical Association 162:628 (Oct., 1956)

6. Berger, Arthur T. and Eisen, Bruno: Journal of the American Medical Association 159:191 (Sept. 1955)

para-amino salicylic acid and/or the isoniazides. Streptomycin may produce a toxic effect on the vestibular division of the cochlear nerve causing vertigo. Di-hydro streptomycin may cause damage to the acoustic nerve causing deafness. A combination of the two in equal proportions reduces the toxic effects.

Para-amino salicylic acid (PAS) taken orally by itself and in combination with streptomycin effectively counteracts the tubercle bacillus. It is relatively safe considering the wide usage and large dosage prescribed. The small proportion of allergic reactions may be counteracted by using graduated increasing oral doses of the drug.

Isoniazides are relatively safe but there have been reports of peripheral neuritis, hepatitis and attempted suicides. The neuropathy is supposedly counteracted by pyridoxine.

The more versatile (broad spectrum) antibiotics are widely used and prescribed. They are effective against a wide variety of bacteria, rickettsiae and protozoa. They can cause gastro-intestinal complaints but super-infections are the most serious complications.

Erythromycin is especially useful for patients who are hypersensitive to penicillin, or for illnesses caused by penicillin-resistant organisms. However, it may produce rash, fever, nausea, vomiting and loose bowel movements.

STEROIDS

THE steroid group here considered includes ACTH given intramuscularly and intravenously; cortisone and hydrocortisone, prednisone and prednisolone given orally. Hydrocortisone and prednisolone may also be given intravenously. All have been prepared into lotions or ointments.

These drugs alleviate the symptoms of allergic disease but do not alter the allergic state. The safest of the group are prednisone and prednisolone but these too may have adverse effects.

Prednisone and prednisolone are the drugs of choice when steroids are to be used, especially when salt and water retention is a problem as in congestive heart disease and cor pulmonale.

In my experience with the newer steroids, there has been a high incidence of gastro-intestinal complications. Symptoms and signs suggesting peptic ulcers are common. There have been reports by investigators of gastric and duodenal ulcers proved by x-ray in patients formerly on cortisone and hydrocortisone, who were switched over to the newer steroid agents.

Patients taking prednisone and prednisolone are advised to avoid highly seasoned foods and to take aluminum hydroxide gels.

When there has been a past history of peptic ulcer, hydrocortisone is preferred. Side reactions to prednisone and prednisolone, besides the ones already mentioned, are insomnia, euphoria, increase of appetite and urinary frequency.

ACTH cannot be given orally. It contains a foreign protein, and therefore may cause severe allergic reaction.

Some of the milder side reactions of the steroids are: weight gain, girdle adiposity, bison hump and moon face.

More serious complications are: osteoporosis, hypertension, psychosis, gastro-intestinal bleeding, masking of infection, and protein depletion.

Burrage[7] in a controlled series of 30 patients, reported that these patients on steroids were maintained essentially free of asthma for periods up to six years. Three of them developed fractures of the vertebrae due to extreme osteoporosis. Also gastro-intestinal hemorrhages were reported as well as masked bronchopneumonia.

One great difficulty with the steroids is the effect of withdrawal after prolonged administration. Nineteen of Burrage's thirty patients[7] who were on continuous corticosteroid therapy for more than a year, had to be hospitalized because of the severe effects of sudden withdrawal. Within 24 hours after withdrawal of the steroid, nausea, vomiting, restlessness, muscle pains and pains in the joints developed in nearly all his patients. It

7. Burrage, Walter S. *et al.*: New England Journal of Medicine 255:129 (July, 1956)

took from two to five days for these symptoms to disappear. Daily steroid therapy had to be resumed in all 19 patients because of the return of severe asthma in spite of efforts to discontinue the drugs.

Steroids should be used only after every effort has been made to make an etiologic diagnosis and to carry out a well planned allergic survey. Often the general practitioner will prescribe the cortisones *before* investigating his patient along established lines of procedure. These steroids should be used only *after* such drugs as potassium iodide, ephedrine, and the like have failed to produce a remission.

In selected cases, steroids are of tremendous value. In status asthmaticus or in severe uncontrolled drug reactions, these hormones are effective. Steroids, however, are not fast enough to be useful in acute anaphylactoid reactions such as one might encounter with penicillin. Here epinephrine is the drug of choice.

Steroids may also be of great value to protect a person over a short period of time in self limited diseases such as severe ragweed pollinosis or asthma.

Complications of prolonged steroid therapy may be reduced by the simultaneous use of antrogen and estrogen which stimulate protein and osseous tissue.

Emergencies while under steroid therapy are becoming more common. Steroids should be continued or increased during surgery, the shock of labor or severe trauma. This is done to make up for the inadequacy of the adrenals at this time, known as the "adrenal exhaustion syndrome."

COMMENT

ALL of these drugs, including the tranquilizers, are presently being used by the general practitioner, the internist and the allergist. We have all seen patients, allergic or otherwise, who have needed tranquilizing agents, who have needed antibiotics, who have needed corticosteroids. These drugs have been life-saving. They have relieved patients of untold anguish and have shortened the duration of their illnesses. The physician should know, however, their actions and particularly their reactions. There are means to combat these reactions. With this anticipation of unfavorable reactions, we should, at long last, be able to rebut Voltaire's slur that "a physician is one who pours drugs of which he knows little into a body of which he knows less."

31 Lincoln Park

Effect of Tobacco Chewing on Circulation

Annual consumption of chewing tobacco in the United States is 81 million pounds. Practically no information is available about its clinical or physiologic effect and specifically its effect on the heart and circulation. Accordingly, habitual male chewers were studied before, during and after chewing both standard commercial and low nicotine tobacco.

Subjects were 24 habitual chewers whose ages ranged between 34 and 71. Each chewed a mouthful of low nicotine chewing tobacco (gum was used in several subjects as a placebo) and a regular commercial brand on the alternative day. Average tobacco chewed weighed 10 Grams. Observations were made in the basal postabsorptive state following a rest period of 45 minutes. The pulse was determined from the electrocardiogram. Blood pressure was taken by a standard sphygmomanometer. Ballistocardiograms were recorded. The subjects were supine and unclothed and chewed for 20 minutes.

The chewing of tobacco in this older group of habitual male subjects produced increase in pulse rates, blood pressure, and drop in skin temperatures, as well as deterioration of the ballistocardiogram, indicating a rather profound cardiovascular effect.

—David L. Simon, M.D. and associates in a paper presented before the American College of Angiology, Chicago, June 10, 1956.

Sherman A. Eger, M.D.

Philadelphia, Pa.

Adrenal Denervation for Hypertension

RESULTS IN 25 PATIENTS FOLLOWED UP TO SIX YEARS*

Many medical and surgical methods have been proposed for control of one of America's most popular maladies: essential hypertension. Here is a surgical technic with a success score of 84 per cent. Dr. Eger gives a step-by-step description which should take the mystery out of the procedure.

In a scientific exhibit† in 1955 and two publications[1,2] in 1956, I introduced an original method for denervating the adrenal glands, described the definite and lasting changes in the adrenals following denervation (from that of hyperactivity to near normality) and showed that this method was beneficial in 5 of 10 essential hypertensive patients followed one to four years. Emphasis was placed on the following: severing of *all* of the 20 or more nerves supplying each adrenal, the preventing of regrowth of these nerves into the adrenals by the formation of a fibrous tissue cocoon-like barrier caused by the placement of oxidized cellulose (Oxycel® cotton) and the selecting of those patients whose hypertension is predominantly neurogenic and whose blood pressure falls from a hypertensive level to normal or near normal during deep sleep (amobarbital sodium test) regardless of age or the duration of the hypertension, providing their cardiovascular-renal status is reasonably good.

Purpose of this paper is to present the latest developments in the original technic and a summary of 25 patients followed up to six years with improvement in 84 per cent.

Since the adrenals are very friable and easily damaged, it is most important to handle them very gently and as little as possible. During the dissection, traction and countertraction are put on the adjacent tissues and structures (kidney, diaphragm and peritoneum) instead of the adrenals themselves. By retracting the kidney downward and medially, the diaphragm upward and the peritoneum medially, the adrenal is in the center of these three forces and its nerves and vessels are held taut in the surrounding fatty areolar tissue. This facilitates identifying the numerous white hair-like nerves which can be dissected free from the adjacent blood vessels by using two long handled hook dissectors. These nerves usually can be severed by a gentle tug on the dissector rather than the more awkward cutting with scissors which is reserved for the larger nerves.

Once through the abdominal wall, hemo-

*Presented before the 191st Annual Meeting of The Medical Society of New Jersey in Haddon Hall, Atlantic City, N. J., General Session on Surgery, April 30, 1957. Dr. Eger is Clinical Professor of Surgery at the Jefferson Medical College of Philadelphia.

†The scientific exhibit was awarded first prize at the 189th Annual Meeting of The Medical Society of New Jersey in Atlantic City, N. J., 1955.

1. Eger, S. A.: Cleveland Clinic Quarterly, 23:160, April 1956

2. Eger, S. A.: Postgraduate Medicine, 19:492, May 1956

stasis by the use of metal clips is preferable to ligatures because of the depth of the wound (6 to 8 inches).

Saline flushing of the adrenal area is less traumatizing than gauze sponging.

For the denervation to be successful it must be complete. This requires good exposure and a careful, systematic dissection performed under direct vision. Dissection blindly with the fingers is dangerous in this region and usually results in tearing of the adrenal or fracturing it resulting in a hematoma within the gland. A hematoma, if formed, should be opened immediately to avoid pressure damage to the rest of the adrenal and possibly necrosis.

Combinations of anesthesia, both endotracheal and intravenous, are satisfactory if agreed upon by the anesthetist and the internist. They should be designed for each patient, depending on their cardiovascular-renal and respiratory status. Good oxygenation of the blood must be maintained at all times. Sudden wide variations in blood pressure should be corrected and stabilized immediately not only during the induction and operating period but in the recovery room as well.

OPERATIVE PROCEDURE

With the patient in full lateral position, the table is flexed about 20 degrees so that the eleventh rib forms the apex and the lumbar muscles are tensed.

The incision begins in the distal half of the eleventh interspace and extends anteriorly for about five inches, parallel to the eleventh rib, and through the tensed lumbar muscles which make it gape. This incision provides better exposure and accessibility to the adrenal than one below the twelfth rib or through resection of the twelfth rib. Accidental opening of the pleura or peritoneum should be avoided and closed immediately. The kidney is then palpated and retracted downward and medially by a malleable retractor at its superior pole. Retracting over gauze is avoided because it does not permit the safety of slipping of the retracted structure during periods of excessive tension which may result in tears. The eleventh rib and diaphragm are retracted upward and the peritoneum medially. At this point the lower edge of the adrenal either comes into view or can be palpated. The peritoneum is then freed from the anterior surface of the adrenal from below upward and the peritoneal retractor is readjusted for maximum exposure.

The actual denervation of the adrenal is best begun at its superior pole where it receives several nerves from both the phrenic plexus and the phrenic nerve avoiding injury to the inferior phrenic vein which is about one eighth inch in diameter and easily recognized. As these nerves are isolated with the hook dissectors and severed, the adrenal is drawn downward somewhat by the transmitted pull from the kidney retractor making it more accessible.

The dissection is continued downward along its lateral and posterior surfaces severing the many nerves coming from the coeliac plexus and the splanchnic nerves.

Attention is then directed to denervating the inferior surface which is difficult to dissect because of the thickness of the perirenal fat in this location. Extreme care must be exercised here in severing the multiple nerves coming from the renal plexus so as to avoid damage to the inferior adrenal arteries (which are branches of the renal arteries or superior renal polar arteries) and the central vein of the left adrenal which usually empties into the renal vein in contrast to the right which usually empties directly into the vena cava and is found at a higher level. Damage to the central vein, resulting in thrombosis (immediate or delayed) or ligation, means necrosis of that adrenal because an accessory vein is rare and usually quite small in diameter.

After completing this area, attention is directed to the medial border where a dozen or more nerves coming from the coeliac and aortic plexuses hold the adrenal snugly against the aorta on the left side and the vena cava on the right. On the left side it is usually advantageous to sever the nerves from above downward along the aorta to the central vein. On the right side it is better to proceed from below upward along the vena cava until the central vein is seen and then from above downward to the vein. On either side it is better to sever the nerves around the central vein last when all of its sides can be seen.

At this point the adrenal is quite mobile since it is held in place now only by its blood vessels. A final inspection is made of all surfaces to make sure that *all* the nerves have been severed and that hemostasis is complete. Biopsy, if desired, should be taken from an area of the adrenal that is not close to any blood vessels especially the central vein.

The completely denervated adrenal is now completely surrounded with a layer of Oxycel® cotton (oxidized cellulose) one inch thick which is soft and compressible and can be readily placed between the blood vessels without compressing them. This amount of Oxycel®, although absorbable, is replaced by a rubbery, fibrous tissue encasement averaging one-half inch in thickness which completely encircles the adrenals and is an impenetrable barrier to the regenerating nerves without impairing the blood supply. This makes the changes in the adrenals, produced by the denervation, lasting and very likely permanent.[2]

The wound is closed in layers around a large Penrose drain to provide escape of a thin brown liquid resulting from the Oxycel®. The drain is removed in about ten days and the drainage usually ceases in another week or two. Prolonged drainage up to two months occurred in six instances and to four months in one.

Patients are permitted out of bed on the second or third day and may leave the hospital in ten to fourteen days. At least a month interval is allowed before denervating the second adrenal so that the first has had sufficient time to recover from any operative trauma. The longest interim has been six months.

Cortisone is given during the second denervation in doses of 50 to 100 milligrams every eight hours for a few days and then gradually diminished to zero in a few days. Prolonged use of cortisone has been necessary in 2 patients.

Other transient complications were atelectasis in 2 instances, ileus in 2 and tachycardia in 5.

RESULTS

In 21 of the 25 cases (that is 84 per cent) blood pressure significantly improved. In 12 of these patients it remained normal without drugs, and in 2 it remained nearly normal. In 7 patients, blood pressure was better controlled with drugs. Four of the 25 patients (16 per cent) failed to show lower blood pressure. Symptoms improved conspicuously in 20 of the 25 patients. Eyegrounds were never worsened and in most patients, the retinoscopic picture was better. Only two of the 25 suffered adrenal insufficiency—an incidence of 8 per cent—and these were controlled on oral cortisone.

PRE-OPERATIVE FINDINGS

Age	Range 25 to 65. Average age: 48
Sex	17 female, 8 male
Ambulatory blood pressures frequently observed	Range from 155/105 to 320/200. Average was 220/130
Symptoms	Headache and "nervous tension"
Eye grounds (Keith, Wagener)	3 were Grade I; 13, Grade II; 6, III; 3, IV
Sodium amobarbital (sleep test)	16 (*i.e.* 64%) became normotensive

POSTOPERATIVE RESULTS:

Blood pressure	Improved in 21 cases—84% Normal without drugs in 12 cases—48% Near normal without drugs in 2 cases—8% Easier drug controlled 7 cases—28% Unimproved in 4 cases—16%
Symptoms	Improved markedly in 20 cases—80%
Eye grounds	Usually improved and never worsened
Adrenal insufficiency	2 cases—8% (oral cortisone 25 mg. per day)
Non-survivals	6 cases—24%

The 6 non-survivals were:

Age	Time	Cause
36	2 months	Uremia
46	1½ years	Uremia
47	2 years	Cerebral thrombosis or hemorrhage
49	24 hours	Congestive heart failure
53	2 weeks	Myocardial infarct
62	1½ years	Cerebral thrombosis or hemorrhage

Six patients (a ratio of 24 per cent) died within 2 years of the operation. One, a 49-year old man, suffered fatal congestive heart failure 24 hours after the operation. One had a myocardial infarct two weeks after surgery. Two died of uremia, one at 2 months and one 18 months after the operation. The other two died of cerebral hemorrhage, one 18 months after surgery, the other 2 years after the operation.

CONCLUSIONS

1. The systematic method of bilateral adrenal denervation described is highly effective in the neurogenic type of hypertension both as to blood pressure and symptoms without causing undesirable side effects.

2. In my opinion, it is a simple but definite physiological approach to a complicated physiological disease.

2029 Delancey Street

DISCUSSION

JAMES R. EYNON, M.D., Camden: I would first like to congratulate Dr. Eger on a fine piece of work. When I was first asked to discuss this paper I had just heard him give a similar presentation before our Camden County Society. I then began to review the literature and the more I searched the more surprised I became. I found that Dr. Eger is a pioneer in this field. I could find only one other reference to denervation of the adrenal in the treatment of hypertension and that was by Cleveland a few years ago. Dr. Cleveland said that denervation of the adrenal glands and kidneys by splanchniceetomy was the most important factor in the surgical treatment of hypertension and that concomitant sympathectomy was necessary in only a very limited degree. Subsequent work has shown, of course, that splanchniccctomy is entirely inadequate in attempting to denervate the adrenals. As Dr. Eger points out, there are about twenty nerves going into the gland from the phrenic, coeliac and renal plexuses. The only sure way to interrupt them all is at the point of entry into the gland. As far back as 1930 Dr. Crile was doing adrenal denervations though not for hypertension. His approach was less visual and no attempt was made to prevent regeneration of the nerves.

The exact cause of "essential," or to use a better term, "neurogenic" hypertension, is still not known. Probably the first surgical approach was made in 1924 with extensive periarterial denervation, but it was soon discarded. The theory behind the procedure was sound, though. They tried to create a greater vascular volume by knocking out the vaso-constrictors and thus lowering pressure. This was carried over into the more extensive sympathectomies. From 1932 to 1940 sympathectomy was rapidly expanded from Adson's limited subdiaphragmatic procedure to Grimson's nearly total thoracolumbar technic with splanchnicectomy. No provision could be made to prevent regeneration of these nerves, however. Associated with the procedure was a great deal of morbidity. The results are far from ideal.

Another small group has been combining subtotal and total adrenaleetomy with limited sympatheetomy and, more recently, total adrenalectomy alone. Results so far published have not been spectacular; to say the least. Sympathectomy and adrenalectomy are pathologic procedures and associated with a great deal of morbidity. This is especially so in adrenaleetomy, for Addison's disease is substituted in the patient. It is then necessary for the patient to follow a very strict and carefully regulated medical regime ever after if he is to survive. Furthermore, even with the best of care, these patients can lapse into adrenal insufficiency quickly in times of stress and unless promptly and competently treated, will be beyond recall in a matter of a few hours.

The medical treatment of hypertension, neurogenic type, has improved greatly since the availability of newer vasodepressor drugs. But this is often associated with undesirable side effects. In spite of a strict regime there are many failures.

Thus, the search for an ideal method of treatment continues and, to me, the procedure of adrenal denervation as presented by Dr. Eger offers many advantages which I would like to point out:

1. It is a physiologic procedure.
2. It is a relatively benign surgical procedure.
3. There are very few side effects.
4. Substitution therapy is unnecessary.
5. The selection of cases is simplified.
6. In this series there has been 84 per cent improvement in cases previously given up as "medical failures."

B. Frank Lovett, M.D.

Camden

Prematurity*

CHALLENGE TO OBSTETRICIANS

Despite advances in obstetrics, prematurity is a major factor in fetal loss. Many obstetricians are fatalistic about this, feeling that the irreducible minimum has been reached. "Not so" says Dr. Lovett, who see this not a cross to be borne, but as a challenge to be answered!

Prematurity is the major area in which the obstetrician may now devote his efforts toward life saving. The concept itself defies absolute definition. In the state of New Jersey any fetus delivered beyond the twentieth week of gestation is considered to be a "viable infant" and any infant weighing less than 2500 Grams is considered to be a "premature infant." Few infants weighing less than 1000 Grams at birth survive so that, for practical purposes, we are more directly concerned with those infants delivered beyond the twenty-eighth week of gestation, which weigh less than 2500 Grams.

Fetal loss in prematurity is directly proportional to the number of premature infants delivered and to the degree of prematurity. Therefore, our efforts must be directed toward the *prevention* of prematurity rather than the *management* of the infant which has been delivered prematurely. Although maternal mortality rates have been reduced and though some maternal complications have been reduced, prematurity continues to occur at an almost unaltered rate. For example, in 1950 in Cooper Hospital there were 3,377 deliveries. Of these, 234 were deliveries of premature infants; this is an incidence of 7 per cent. Of these infants, 143 were in group A, weighing 2000 to 2500 Grams; 47 were in group B, weighing 1500 to 2000 Grams; 29 were in group C, weighing 1000 to 1500 Grams and 15 were in group D, below 1000 Grams. The perinatal mortality rate in the first group was 5 per cent; in the second group, 38 per cent; in the third group, 62 per cent. In the last group, there was only one surviving infant, a mortality of 93 per cent. An interesting feature is that prematurity occurred on the Ward Service in 11 per cent of ward deliveries while prematurity occurred on the Private Service in 4.2 per cent of deliveries; in other words prematurity was two and one-half times more common in the Ward than in the Private Service. A comparison with the figures for 1955 reveals almost exactly the same relative figures.

In 1950, there were 7,770 premature deliveries in New Jersey, an incidence of 8 per cent. In 1955, there were 9,562 premature deliveries, an incidence of 8 per cent. The Division of Vital Statistics of the State Department of Health[1] computes mortality on the death rate of live born infants; this varies slightly from the total fetal loss quoted for Cooper Hospital. In 1950, in New Jersey, the death rate during the first year of life of premature infants was for group A, 5 per cent; for group B, 20 per cent; for group C,

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59 per cent; and for group D, 92 per cent. In 1955 the neonatal death rate in the first four weeks of life were: for group A, 3½ per cent; for group B, 17 per cent; for group C, 48 per cent; and group D, 86 per cent. Comparable figures for the two years are not available; however, there is a hopeful suggestion that premature mortality rates are being reduced.

Prematurity is two and one-half times more common on the Clinic Service. In our Obstetrical Ward Service 15 per cent of the patients are unregistered, non-clinic patients. A fifth of prematures occur in this group. An additional 12 per cent of premature deliveries occur in those patients who have made only one or two visits to the clinic.

DIET

In the field of nutrition, Thompkins [2] and his co-workers have presented well regulated studies over a period of many years. Their findings are convincing but have been challenged by some. According to Thompkins, patients on a marginal balanced diet, when supplemented with proteins and vitamins had a reduced incidence of premature deliveries. Excessive weight gain was associated with an increased incidence of prematurity. Failure to gain at the normal rate is associated with a greater increase in the premature rate; this was particularly noticed in undernourished women who failed to gain weight early in the pregnancy. Studies by the Vanderbilt group [3] tend to contradict these statements. It was the opinion of this group that the caloric intake should be considerably lower than the established standards and that reductions in protein intake were usually the result, and not the cause, of the disease during pregnancy. Furthermore, it was their opinion that more mature babies do not result from the increased intake of proteins and vitamins. Oldham [4] questions the value of high protein, low caloric diet in the management of obstetrical patients. She has shown that, in the absence of an adequate caloric intake, the body does not utilize protein, regardless of the quantity of protein ingested. We may, therefore, need to revise our standards of caloric intake upward to some degree. In any event, the interests of the patient can be best served by providing her with a well balanced diet, adequate in proteins, minerals and vitamins to meet the demands of the pregnancy. It might also be added that a reduced intake of sodium may be advantageous in reducing the incidence of hypertensive complications arising during pregnancy.

In approximately 60 per cent of all cases, the etiology of premature labor remains unknown. The psyche may play a part in the onset of labor in this group. Most authorities agree that sexual intercourse stimulates uterine contractions. Certainly the patient with a history of premature labor or one who has exhibited signs of threatened premature labor should abstain from coitus.

PREMATURE RUPTURE

Premature rupture of the membranes is one of the more commonly associated factors in the spontaneous onset of premature labor. Whether this represents a response to uterine contractions with increased intrauterine pressure resulting in the ruptured membranes is not always clear. Hypoplasia of the uterus has been suggested as a cause of premature rupture of the membranes, as have endometrial deficiencies prior to the onset of pregnancy. Multiparous women with a history of previous premature labor are more likely to have a subsequent premature labor. Premature labor is more commonly seen in the young primagravida. Whether this represents a uterine or a psychosomatic effect remains undetermined.

What should the obstetrician's management be when premature rupture of the membranes does occur? Because of the incidence of ascending intrauterine infections with resultant pneumonias, empyema, and bacteremia involving the fetus, we feel that the best interest of the child and mother are served by induction of labor if premature rupture of the membranes occurs beyond the thirty-sixth week of gestation and can be proved to the reason-

able satisfaction of the obstetrician. Premature rupture of the membranes when it occurs at an earlier stage of gestation has been managed at The Cooper Hospital by the administration of Progestone® in dosages up to 600 milligrams per day, at bed rest, and by the administration of antibiotics to prevent infections. Treatment with a versatile antibiotic substance enhances the growth of non-sensitive pathogens and less virulent organisms. Infectious fetal complications have been reduced by antibiotic therapy. Although such measures frequently fail, an appreciable number of pregnancies have been continued for as long as thirty-five to forty-two days, permitting thereby the delivery of viable infants.

BLEEDING

HEMORRHAGIC complications of pregnancy constitute another factor in the causation of prematurity. Placenta previa continues to occur with almost unchanging frequency. For several years the conservative therapy as advocated by Johnson[13] has been followed. If the diagnosis of placenta previa is made at or beyond the thirty-sixth week of gestation, the pregnancy should be terminated at that point by the appropriate means. At a stage of gestation earlier in the pregnancy the dangers of prematurity may well out-weigh the dangers of subsequent hemorrhage from a placenta previa. Such patients admitted to the hospital bleeding should be given a period of rest during which time they should *not* be examined. Subsequent to the cessation of bleeding, examination can be performed to establish the diagnosis of placenta previa. A patient with a marginal or low-lying placenta may even be permitted to go home to await a more advanced stage of pregnancy. Patients with total placenta previa, or multipara with a soft cervix who may enter into a rapid labor should not be permitted to leave the hospital. Such a conservative approach has not greatly endangered the lives of women, and certainly has been one of the major advances in recent years toward increasing fetal salvage in this field. Abruption of the placenta, of major degree, usually constitutes a serious hazard to the infant and often to the mother; the obstetrician under this circumstance has little or no opportunity to give major consideration to the problem of prematurity. It is questionable whether cesarean section offers a greater opportunity for salvaging either the premature or term infant, but is worthy of consideration. The patient with a minor degree of abruption, with bleeding of relatively minor degree, in the absence of other pathologic changes which would necessitate delivery, may well be continued in her pregnancy until the infant develops to a more mature state. It is not uncommon to observe the patient, who at term, delivers a placenta and an organized clot which must have been present for weeks prior to delivery. If such patients can proceed to term without any external evidence of bleeding, then certainly some of those patients with minor degrees of abruption of the placenta can be managed conservatively. A word of warning is in order, however: patients managed in such a conservative manner may subsequently develop massive abruption of the placenta and all of the attendant complications. Also, infants delivered from mothers who have hemorrhaged may suffer from acute blood loss. Early transfusion of the infant will improve the opportunity for fetal salvage.

MULTIPLE PREGNANCY

MULTIPLE pregnancy is another factor often associated with premature labor. A rapidly growing uterus, which early in pregnancy becomes disproportionately large, should suggest the possibility of a multiple pregnancy, and efforts should be exerted to establish an early diagnosis. Reduction of physical activity, increased bed rest and sexual abstinence will reduce the incidence of early onset of labor.

ECLAMPSIA AND HYPERTENSION

THERE are additional factors in the development of prematurity over which the obstetrician has greater control. He may be unable

to prevent the process, but he may at least choose the time of delivery. In this group will be included pre-eclampsia, hypertensive cardiovascular disease complicating pregnancy, repeat cesarean sections, and the elective induction of labor.

In spite of improving prenatal care there has not been a remarkable decrease in the incidence of pre-eclampsia; this continues to range between 6 and 8 per cent. At the Cooper Hospital, pre-eclampsia constitutes the most common indication for the induction of labor. Pre-eclampsia is a definite hazard to the patient and unborn infant. Continuation of the pregnancy in the presence of pre-eclampsia exposes the mother to the danger of eclampsia, the possibility of permanent hypertensive disease, and reduces the opportunity for fetal salvage.[5] Termination of pregnancy, therefore, is definitely indicated in both the maternal and fetal interest, regardless of the stage of gestation. *Prematurity is a lesser danger to the infant than continued intrauterine existence in the presence of pre-eclampsia.* The termination of pregnancy should be predicated upon a positive diagnosis of pre-eclampsia established by an adequate period of observation and study. The infant should not be subjected to the hazards of prematurity on the basis of an "impending toxemia" or "suspected pre-eclampsia."

THE diagnosis of essential hypertension may be difficult to establish except in the hypertensive primagravida early in the pregnancy; however, this disease involves many others. Although essential hypertension alone may be associated with an increased incidence of premature separation of the placenta, this disease when uncomplicated by a superimposed pre-eclampsia, is not a great hazard to the maternal or fetal organism.

Most patients with essential hypertension will show rising blood pressure in the latter weeks of pregnancy to levels which may become alarming. However, in the absence of superimposed pre-eclampsia, such a rise in blood pressure does not constitute an indication for premature termination of the pregnancy. Approximately 25 per cent of such patients with essential hypertension may be expected to develop a superimposed pre-eclampsia. In this group one may expect a high incidence of abruption of the placenta, intrauterine distress or fetal death. Patients with benign essential hypertension may be carried under close supervision to a point at or near term, so that the welfare of the infant need not be compromised unnecessarily by early induction of labor. In the absence of pre-eclampsia, the danger of impending premature separation of the placenta is a lesser danger than prematurity brought about by injudicious interruption of the pregnancy. Pregnancy should be interrupted when pre-eclampsia develops or when progressive vascular or renal disease can be demonstrated by ophthalmologic studies or renal function tests. In the management of labor one should choose the drugs which are not dangerous to the infant. Large doses of narcotic or hypnotic drugs should not be used in an effort to reduce the degree of hypertension of the mother. Such drugs have a profound and undesirable effect upon the premature infant. Under such circumstances, it is better to use those anti-hypertensive drugs which do not have a deleterious effect upon the infant. Apresoline® and viratrum alkaloids have been shown by McCall[14] and others[15] to be effective in reducing the maternal blood pressure, while improving the maternal cerebral and renal blood flow. These drugs have no depressant effect upon the unborn infant. Reserpine in doses of 2.5 to 5 milligrams, given intramuscularly during labor to reduce the blood pressure of the parturient, has a profound depressant effect upon the unborn infant and should not be used in premature labor.

ELECTIVE INDUCTION

ELECTIVE induction of labor for the convenience of the patient and/or her obstetrician may, under many circumstances, be reasonably indicated. We at the Cooper Hospital have for a few years performed an "elective

induction for convenience." However, these are relatively few. They are done on patients who live a considerable distance from the hospital and who have had previous rapid labors. Although the incidence of inductions of labor at Cooper Hospital approximates 6 per cent, most of these inductions are indicated on the basis of intercurrent obstetrical complications. Of course, any induction of labor is associated with some small degree of danger to the infant, not the least of which is prematurity. We are all prone to error in the estimation of the weight of an unborn infant. Even in the presence of a "ripe" cervix, induction of labor may result in the delivery of a premature infant. Bishop[6] reported 4 additional prematures in a group of 1000 elective inductions, with no fetal mortalities. Taffeen[7] found a 5 per cent incidence of premature infants in a group of elective inductions of labor. There was one neonatal death in this series of 510, directly attributed to prematurity. The delivery of any premature infant after the elective induction of labor would seem an inexcusable error, which could be avoided if the obstetrician did not perform elective inductions.

SECTIONS

Repeat cesarean section is another field in which the obstetrician may be the motivating agent in the production of prematurity. The menstrual history may be unreliable and estimation of fetal maturity is difficult and often in error. Most obstetrical departments are embarrassed from time to time by the delivery of a premature infant by elective repeat cesarean section. Such an infant may or may not survive. Under spinal anesthesia, given for cesarean section, fetal oxygenation is reduced and physiology of respiration is altered. More profound and prolonged changes in fetal oxygen saturation occur if general anesthesia is used. To superimpose these changes in physiology upon a premature infant is an unwarranted hazard. In all of the series of elective repeat cesarean sections the authors report a considerable incidence of premature infants. Some of these are correctable and not attributable to the procedure itself; yet such an incidence of prematurity does exist. Birnbaum[8] finds 14 per cent of premature births in this category with a perinatal mortality rate of 50 per cent. In fairness, it must be said that this figure is correctable, and only one of six neonatal deaths was directly attributable to prematurity. Gordon,[9] reporting on 2693 cesarean sections for all indications, reports the incidence of prematurity as 11 per cent; of 1042 elective repeat cesarean sections, there were 30 neonatal deaths, 20 of them in prematures. This was the largest group of neonatal deaths in his series. In view of published experiences at The Margaret Hague Maternity Hospital and at The New York Lying-In Hospital concerning the vaginal delivery of patients after previous cesarean sections, it would seem that the delivery of a premature infant by elective repeat sections can be avoided. When any question exists as to the maturity of an infant to be delivered by repeat section, there is little increased danger to the mother or child if that patient is permitted to go into labor. I cannot here discuss the problem of vaginal delivery after previous sections; but the occurrence of labor would indicate that termination of pregnancy must be contemplated by one means or another. At that point, maximum maturity will have been obtained. Finally, if a conservative attitude is maintained toward the indications for the initial cesarean section, many sections can be avoided and the problems related to subsequent sections obviated.

MEDICATION

Sixty per cent of patients enter into premature labor without any apparent cause, and efforts should be exerted to prevent the progression of premature labor. In management, bed rest is an essential requirement. Mild sedation with a barbituric acid derivative given early in labor is not harmful and probably is beneficial in relieving some of the psychic stress. The value of opiate drugs is open to some question; textbooks of pharmacology say that morphine and meperedine *reduce*

uterine contractions, but I have long felt that these drugs actually *stimulate* uterine contraction or, at least, hasten cervical dilatation. They do have a prolonged undesirable effect upon the infant. On the other hand, progesterone in rather large dosages varying from 200 to 600 milligrams per day is beneficial. However, progesterone will not stop an established premature labor. A new ovarian derivative, a water soluble, non-steroid hormone[10] extracted from the corpora lutea of pregnant sows has been used experimentally[11] with results reported with a varying degree of enthusiasm. I have had no experience with it. Many authors[10,11] report it to be effective in premature labor when the cervix has not become dilated beyond three centimeters. Although this drug reduces uterine contractions it has the objectionable property in threatened premature labor of producing increased cervical softening. It is an expensive drug which has not come into general use and is, at the present, of questionable value. It is certainly worthy of consideration and further observation and possible wide usage in the future.

ANALGESIA AND ANESTHESIA

SINCE efforts to prevent prematurity have, to the present, failed to reduce the incidence of prematurity, the obstetrician must determine how labor may best be managed to improve fetal salvage. Such a discussion must of necessity touch upon the subject of analgesia and anesthesia. This is the subject material of a paper now being prepared by another member of the Obstetrical Department at the Cooper Hospital,[12] and I am grateful to Dr. Gaines for his analysis. It is my personal conviction that the patient in premature labor should receive no narcotic or hypnotic drugs during labor, and that delivery is best managed under a regional anesthetic such as pudendal block. With the emotional support of the presence of her obstetrician, the average woman is willing to undertake the pain of labor without analgesia if the advantages to the infant be explained to her. Also, she is willing to undertake delivery with an anesthetic agent which under ordinary circumstances she might consider undesirable. Delivery without analgesia or anesthesia has resulted in the greatest mortality rate to premature infants. This is particularly true of the primagravida. It is a reflection of the damage of a precipitous delivery which does not permit time for administration of an anesthetic agent and the delivery of the infant under control. Under such circumstances, inhalation anesthesia administered over a very short interval will permit a controlled delivery with forceps over an adequate episiotomy. This would be less damaging to the infant, than a precipitous delivery. Best results were obtained by the administration of no analgesia during labor, the administration of a local infiltration or pudendal block anesthesia and the delivery of the infant with forceps over a wide episiotomy. The administration of standard dosages of analgesic drugs and a general anesthetic for delivery resulted in a poor infant salvage. In general a term infant will tolerate the administration of standard dosages of such drugs and the administration of inhalation anesthetics. Those prematures in the weight group from 2000 to 2500 Grams tolerate such medication almost as well as a term infant, showing only a slight reduction of fetal survival. Those infants in the group from 1500 to 2000 Grams did best on the regimen of no analgesia and the administration of pudendal block with delivery with forceps over a wide episiotomy. In the group of infants from 1000 to 1500 Grams, there was little difference in the survival rate regardless of the analgesic or anesthetic agents administered or eliminated in the management of the case.

SUMMARY

OBSTETRICIANS cannot assume that prematurity is an irreducible factor contributing to fetal loss. Prematurity occurs 2½ times more frequently in patients at a poorer socioeconomic level. This suggests that there are correctable factors which can be discovered. Since this occurs with the greatest frequency in patients with little or no prenatal care,

proper care must be extended to these women by increasing financial aid from one source or another in order to make adequate care available. A conservative attitude toward the management of the complications of pregnancy which may lead to prematurity will serve to reduce the incidence of prematurity, and the proper management of premature labor when it does occur will serve to reduce the associated fetal mortality rate.

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Fibrosis of the Appendix

Bowers and Pixley, writing in *Military Medicine* (116:345, 1955) report on a study of 649 appendectomies. In 81 per cent of these, acute appendicitis was reported by the pathologist. Of particular interest was the group of 105 patients, representing 16 per cent of the series, in whom symptoms of acute appendicitis were present but at laparotomy showed no evidence of acute inflammation. Of this group, 9 per cent showed marked fibrosis and 3 per cent showed mild fibrosis on azocarmine stain. In the marked fibrosis group, 70 per cent had a positive history of previous attacks of right lower quadrant pain and 86 per cent experienced complete relief after appendectomy. In the cases where no pathologic changes could be shown at all, 6 per cent had no further pain although only 15 per cent gave a past history of previous attacks.

Fibrosis of the appendix can be recognized even though the pathologist may report, on cursory examination, "normal appendix." The characteristic gross feature was thickening and rigidity of the wall, with loss of the soft, compressible feel. In all cases where there was a long-standing history of repeated attacks, adhesions and abnormal bands were found in the region of the cecum and appendix. The mesoappendix frequently was short and thickened. The lumen usually was dilated just distal to the obstruction, but complete obliteration of the distal lumen was a common observation.

Marked fibrosis of the appendix presents clinical symptoms, the most prominent appearing to be intermittent cramping pain of the right lower quadrant. Most patients had abdominal tenderness limited to the right lower quadrant. The total leucocyte count and the differential count were normal in 90 per cent of the patients in this group. It would appear that the appendix becomes fibrosed as a result of repeated minor inflammatory episodes, and that appendectomy is a proper treatment for this condition.

James H. Spencer, M.D.

Newton

The Care of the Injured*

A PRACTITIONER'S CHECK LIST

The glamour of the new drugs and the increasing interest in biochemical problems (like electrolyte balance) have taken the spotlight off something that was once the MD's major problem: the immediate care of the injured. Are we abandoning this to first-aid men? If so, we are not meeting our responsibilities here. As Dr. Spencer shows in this unusual monograph, there is need for a renaissance of traumatic surgery.

The care of the injured should be the concern of both surgeons and general practitioners. They will find in this field, thrills, surprises, difficult diagnostic problems and rewarding experiences equal to those in any branch of medicine. Some think that the surgery of trauma lacks appeal because it is based on old, well established principles and is thus devoid of novelty. However, an observation of what goes on in the accident rooms of some well rated hospitals, leads to the conclusion that some of these old and well established principles need restating. I will confine my discussion to a few areas that are often neglected, namely:

1. Keeping the patient alive.
2. The importance of the history of the accident and of pre-existing conditions.
3. Surgical care of the open wound.
4. Penetrating injuries.
5. Team work.

Keeping the patient alive is, obviously, fundamental. Injured people who survive the first impact of the injury may die from asphyxia, shock, hemorrhage or infection. The rapidity of death from these causes is probably in that order. The physician experienced in the surgery of trauma can recognize the sound of an inadequate airway as he approaches the accident room or wherever he sees the patient. He must pull the tongue forward, lift the jaw forward, put in an airway or do a tracheostomy without delay. If he fails to do that he may not have the opportunity to render any other service to the patient. It is trite but true that the time to do a tracheostomy is when you first think about it. Later, may be too late. Any condition that seriously reduces the respiratory reserve, may require this treatment. Remember, it is a treatment, not just an operation. The care of the tracheostomy tube requires not only skill, but eternal vigilance. If trained personnel is not available, someone must be instructed on the spot.

INFECTION AND SHOCK

The best time to treat shock is before it occurs. It was my privilege to take a course in war surgery at the British Post-Graduate Medical School, in London, in 1942. I would

*Read April 30, 1957, Session on Surgery, Annual Meeting, The Medical Society of New Jersey.

like to pass on two statements copied from the notes I took during that course. Prof. R. S. Pilcher, in his discussion of the management of shock stated, "The attitude to take is that any severely injured patient is going into shock, regardless of his blood pressure or pulse when we see him." And Dr. Janet Vaughan, who had a wide experience in transfusions during the London blitz, remarked, "The only real guide to treatment is the seriousness of the injury, regardless of hemoconcentration." These opinions from physicians who had dealt with mass casualties and under circumstances where technical laboratory studies were often out of the question serve to reinforce the point that the nature of the injury must be considered. I will have more to say about this later.

Hemorrhage is a great killer and is one of the prime causes of shock. Emergency measures may often be needed to stop it and it is one of the few real reasons for rapid surgery.

Infection is a more insidious cause of death and consequently less respected; but its dangers must not be discounted. Fortunately, we can usually prevent this.

GETTING A HISTORY

A FEATURE of the surgery of trauma that is too often forgotten is the *history* of the injury and the medical history of the patient before injury. Naturally the surgeon does not take a long and detailed history on a badly injured patient, while the patient's condition deteriorates because of lack of immediate care. But much information may be obtained [1] while one is inserting an airway, applying a dressing or putting on a splint. Information may be collected from the patient, his friends or family or other witnesses to the accident. The mechanics of the accident may throw light on the probable injuries. The speed of a car, the velocity and weight of a flying object, the position that the patient was in when injured are all worth investigation. Pre-existing disease or abnormalities of the patient may have increased the damage from what seemed like minimal trauma.

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CASE ONE

A sixteen-year old boy was admitted to the Newton Memorial Hospital at 1:00 a.m. He had fallen on the ice while skating the afternoon before. He had walked home and offered few complaints at the time. He began to pass blood in his urine later and had fainted once. I had seen this boy a few days before, because of a swelling in his neck, and was arranging to have him admitted to the hospital for a biopsy, but I had not yet done a complete physical examination on him.

I saw him promptly on admission and found considerable tenderness and muscle spasm in the left flank. The catheterized urine specimen was bloody. I quizzed him specifically about the mechanism of the accident, particularly asking if he had fallen on a log or stone or any other object. He denied this, saying that he had just fallen on his left arm because he had had his hands in his pockets. I reasoned that with his hands in his pockets, he had not been skating very fast and that the trauma to his left flank was not sufficient to cause severe damage to his spleen or left kidney. I thought he had intracapsular damage to his kidney. Intravenous pyelogram showed what appeared to be an abnormal collection of dye in the left flank at the level of the tenth and eleventh ribs, but not a diffuse spread of dye such as is often seen in severely ruptured kidneys. The pelvis and calyces of the right kidney were normal. He was immediately typed and transfused. For 48 hours we watched the slight decrease in the redness of his urine and kept pace with his blood loss with several transfusions. Although he looked and felt better at the end of this time, it was evident that further effort to save his kidney was futile. On operation, we found a large polycystic kidney, very adherent and ruptured along the hilar border. The collection of dye that we had seen (and which was well circumscribed on the film) was not from leakage, but was in a large unruptured cyst in the upper pole. The pathologist said that this was a very rare condition: a unilateral true polycystic kidney. If this boy had had a complete physical examination before the injury, the enlarged kidney might have been found and its susceptibility to rupture from minimal trauma suspected.

Patients suffering from splenomegaly or enlargements of the liver are more susceptible to traumatic damage to these organs than if the organs were normal. Certain physiologic conditions, such as a full bladder or full stomach predispose to greater injury from external force. Failure to obtain an accurate history of these pre-existing conditions or the details of an accident may lead to embarrassing errors in diagnosis or treatment. Failure to obtain the history of an accident may not be the fault of the physician. The patient or others may deliberately withhold essential informa-

tion. I was once surprised, although not embarrassed, to find a ruptured spleen when I operated at midnight for what three physicians (including myself) thought was a perforated peptic ulcer. The patient had been under treatment for ulcer for several years and his symptoms had recently been aggravated. His story of the onset of the pain and his physical findings were compatible with perforated ulcer. He had purposely withheld the story of a fight with his brother fourteen hours earlier. He had been kicked in the left flank, but did not want to get his brother into trouble.

CARE OF THE OPEN WOUND

Correct wound care has several aims, the most important of which is the prevention of infection. This mission is predicated on a clear distinction between contamination and infection. If a man sustains an open fracture in a dirty barnyard, his wound is not infected at first. To be sure it may be loaded with lethal bacteria, but it is not infected. This gives us our chance to obtain early healing and thus restoration of function. The two factors that will convert contamination into infection are time and devitalization. Fortunately, we can usually control both of these.

1. Contamination plus time equals infection and delayed healing
2. Contamination plus devitalization plus time equals greater infection
3. Contamination plus early adequate surgery equals no infection or reduced infection
4. Good surgery plus no infection equals early primary healing and return of function

A fundamental frequently forgotten in dealing with open wounds is the fact that just because a wound is already dirty, it is not immune to further contamination. It is hard to understand why the same doctors will array themselves in sterile cap, mask, gown and gloves for the elective removal of a sebaceous cyst, just because it is being done in the operating room; and later the same day when confronted with a large open wound in the accident room, quicky pull on a pair of sterile gloves over unscrubbed hands and attack the wound while carrying on a conversation that is probably spreading droplet contamination, because of the unmasked face. Wound surgery, to be successful, must be good surgery and good surgery is aseptic surgery.

Too much reliance has been and still is placed on agents other than the scalpel. The object is to get the germs out of the wound, not to kill them *in situ*. Although this method of treating wounds has been improved and refined in the last few decades, it is not new. Petit is said to have practiced debridement in the eighteenth century in France and John Hunter [2] understood some of the fundamentals of modern wound treatment. His wide experience as a military surgeon and his keenness of observation taught him things that have been forgotten and relearned many times since. Without our knowledge of bacteriology, he did understand something about infection and warned that an abscess might form if certain types of gunshot wounds were not opened. He suggested the advisability of making an opening, ". . . that fractured bones or extraneous bodies may now or hereafter be better extracted . . ." This was at least a hint at our modern concept of toilet of the wound.

To other French and British surgeons of the early twentieth century must be given a full share of the credit for the successful way that wounds are treated today. World War I provided them with an opportunity unequaled up to that time, to study the care of wounds and establish some principles that have stood the test of time. Leriche,[3] a French surgeon, wrote one of the many military medical manuals published in England in 1918. In his introduction to the subject of the care of wounds he states, "The reader will be surprised perhaps that I have not recommended in this treatise the use of any antiseptic. I have not done so because, in my opinion, none is really necessary if the surgical treatment has been carried out correctly." He then goes on to de-

2. Hunter, John: A Treatise on the Blood, Inflammation and Gunshot Wounds. London, England, 1793. William and Unwin. Page 523.

3. Leriche, R.: The Treatment of Fractures. Vol. I. Introduction p. XXX. London, 1918. Macmillan.

tail the complete surgical cleansing or excision of a wound in terms that would do credit to any well versed surgeon today. British surgeons learned the same lessons and preached and practiced wound excision, although some of them did rely on antiseptics also. Morison[4] wrote his monograph on "Bipp Treatment of War Wounds" in March, 1918 and I can recall hearing the senior Fraser Gurd singing the praises of B.I.P.P. paste, when I first began taking an interest in this subject twenty years ago. This paste liberated free iodine in the wound through the action of bismuth subnitrate on iodoform and British surgeons in the African campaign in World War II used a paste called Z.I.P.P. in which zinc oxide was substituted for bismuth subnitrate. Bailey[5] is probably right when he hints that the success of the B.I.P.P. treatment may have been more due to the drainage provided than to the particular chemical used. The Carrel-Dakin method of trying to prevent and treat wound infection was in vogue when I was taking my formal training. I gave it up a few years later when I found a nurse irrigating my carefully placed tubes with a medicine dropper!

The sulfa wave was at its peak in the early nineteen forties and 5 to 20 Grams of various sulfa crystals were being placed in wounds. Reports from Pearl Harbor and those of Ferguson and others show the value of the use of sulfa crystals in open wounds as a means of preventing infection, but there is also ample evidence that they interfere with primary union because they act as irritating foreign bodies. Increased experience led to the systemic use of sulfa therapy. It is unfortunate that the benefits of sulfa prophylaxis have been overshadowed by the newer and more dramatic antibiotics. Sometimes we profit by looking back in medicine. A wider use of the comparatively safe sulfa combinations we have available today might be a partial answer to the antibiotic orgy from which we have been suffering. Many of these chemical and biologic agents have been useful; but no agent has yet been found that can be put into a contaminated wound with assurance that it will prevent bacterial growth and not interfere with wound healing. Good surgery remains the basis of good wound care. The fundamentals of good wound surgery are:

1. Removal of foreign bodies
2. Wound excision
3. Wound cleansing
4. Wound dressing and fixation

Adjuvants to good surgery are:

1. Antibiotics
2. Chemotherapy
3. Antitoxins and toxoids

The important thing is what you take out of the wound, not what you put into it.

As is so often the case, the simplest and least dramatic treatment has proved the best. The simplicity of good wound treatment has stripped this therapy of its glamour and led so many physicians to neglect it. Any physician, with a modest knowledge of anatomy and the willingness to adhere to certain fundamental principles, can treat a wound in expert fashion.

FOREIGN BODIES

FOREIGN bodies, whether they be bullets, shell fragments, splintered wood, bits of clothing, fragments of detached shattered bone or just dirt will act as irritants. They should be removed. Torn and contused skin, fascia and muscle are devitalized and will only remain as culture media. They should be removed. Any open wound has had microorganisms introduced into it. They should be washed out. And finally, since the entrance of other foreign bodies or microorganisms should be prevented, the wound should be dressed and then fixed in such a position that normal physiologic processes may continue with as little interruption as possible.

The finding and removal of foreign bodies may be aided by x-ray studies. The excision of devitalized tissue requires some skill, but mainly patience. It is best done with the scal-

4. Morison, Rutherford: "BIPP Treatment of War Wounds." Edward Arnold, London, 1918.

5. Bailey, Hamilton: Surgery of Modern Warfare, Vol. 1, p. 109, Edinburgh (Ed. 2), Balliere and Tindall, 1942.

pel, but sharp scissors will be useful under certain circumstances. There are some areas, particularly the face and over joints and tendons, where skin excision must be kept to the minimum, to obviate the necessity of grafting. Fortunately the rich blood supply of the skin of the face makes this area less likely to devitalization from trauma.

CLEANSING AND IRRIGATION

WOUND cleansing begins with thorough cleansing of a wide area around the wound. Chronologically, this should precede the steps already mentioned. While this is being done the wound itself should be protected with a sterile gauze pack or plug. This will guard against further contamination from outside. The best agents available for this washing are the liquid hexachlorophene preparations. These are distributed under the names of pHisoHex® and Septisol®. They contain a synthetic phenol compound known commercially as "G-11." Walter [6] states that a two minute scrubbing of the skin with one of these preparations lowers the resident bacteria count more than twenty minutes scrubbing with ordinary toilet soap.

Preceding and following the excision of devitalized tissue, the wound should be thoroughly irrigated from within out, in order not to wash foreign particles and bacteria deeper into the wound. This may be done best with the use of a Kelly bottle to which is attached a long rubber tube with a glass tip. For small wounds, an Asepto® syringe is quite satisfactory. Sterile saline is the only agent necessary although a diluted G-11 Solution® may be used followed by saline. The important point is to wash the wound thoroughly. Large wounds frequently need alternate excision and irrigation as the irrigation may be necessary to indicate what tissues have been deprived of their blood supply. Muscle that appears light colored, resembling the tissue of fish, will not return to life. Red muscle that oozes blood will live.

The mechanics of wound irrigation seems to deter some doctors because of its sloppiness. It can well be taken care of by some kind of a pan, preferably square or rectangular, covered with a grid of aluminum or steel. A drainage hole in one corner of this allows the saline washings to run through a rubber tube to a bucket below. Walter [6] pictures one of these in his 1948 book, but I saw it illustrated earlier in the *British Medical Journal* and have made one from an enameled pan and a steel grill salvaged from a cast-off refrigerator.

DRAINAGE, REPAIR AND CLOSURE

VITAL structures, such as blood vessels and nerves must of course be preserved. If they have not been severed or crushed, they will probably survive. If nerves have been severed and are large enough to repair, decision must be made as to primary or secondary repair. Primary repair is usually inadvisable, except in fairly clean wounds treated early. With severed vessels, the size and importance must be considered. A severed major vessel in an area with poor collateral circulation or where the collateral circulation has been compromised by the injury calls for an attempt at repair.

The closing of wounds following excision and irrigation calls for judgment that is hard to define. Even large wounds that are not badly soiled may be closed with impunity in many instances. Just how thoroughly to close them is also a matter of judgment. Two things can be categorically stated. *Hemostasis must be as complete as possible and dead spaces must not be left,* particularly if hemostasis is not perfect. When a wound has been treated within a few hours of its occurrence, and there is good reason to believe that little contamination remains much healing time can be saved the patient by closing the skin with interrupted silk or cotton, provided there is no dead space beneath and the hemostasis is good. When I am in doubt about these factors, I like to drain. This may take the form of a loose vaseline gauze strip or strips in an open wound or a strip of soft rubber in a partially

6. Walter, Carl W.: Aseptic Treatment of Wounds. Ronald Press, New York. P. 180. 1948.

closed wound. I make every effort completely to cover exposed tendons and bone with at least a layer of skin. Chest wounds must be closed to prevent lung collapse and those joint wounds without severe damage to the articular surfaces should have at least the synovial membrane closed. I do not drain abdominal wounds if I have been satisfied with my surgery.

DRESSINGS

THE application of a dressing needs little discussion, except to say that the dressing should completely cover the injured area and the bandaging should be snug but not tight. Circulation must be protected. If some pressure is needed to prevent oozing, this can be more safely attained with an elastic bandage than with non-elastic gauze bandage. Splints are required for the fixation of some type of wound, even without fractures. They are invaluable in preventing tension on repaired tendons, nerves or blood vessels and in preventing the shifting of tissue planes in a wound that needs rest.

DRUGS

WITH regard to the use of antibiotics and chemotherapy, which I classify as adjuvants to adequate surgery, they are valuable as long as they do not lead the surgeon to neglect the fundamentals. Ferguson,[7] instructs his residents not to use antibiotics and sulfa drugs in the care of accidental wounds and I think that this is sound surgical teaching. His residents are more likely to debride well and irrigate well, than if they were leaning on an antibiotic crutch.

Penetrating injuries include wounds caused by guided weapons, such as knives, ice picks, bayonets or other non-projected implements or unguided missiles, such as bullets, shell fragments or other flying objects. The course taken and damage done by a *controlled* object such as a knife may be estimated if an accurate history of the wounding is available. A knowledge of anatomy is invaluable here, but no organ must be considered as always lying in the same position. Anatomic relationships are subject to marked and rapid changes with body motion and positioning. All possible organs must be thought of in this type of injury.

The course taken by a flying object that penetrates or passes through the body presents no fixed pattern and all possibilities must be considered. The varying resistance of structures may bring about the most surprising results as the velocity of the object decreases. The x-ray is useful in locating the final resting place of a retained missile, but the course of the missile may not have been a straight line between the wound of entrance and the final resting place. John Hunter[8] had this to say about the course of missiles, "The regularity of the passage of a ball will in general be in proportion to its velocity and want of resistance, for balls are turned aside in inverse proportion to the force that they come with, and this is the reason why we seldom find them take a straight course; for if they are spent balls, the soft parts alone are capable of turning them; and if they come with a considerable velocity it is a chance they may hit some bone obliquely, and then they are also turned aside, for any body which gives a ball the least oblique resistance throws it out of its direct course; therefore the balls that do not pass through (which are the only ones searched after) will be in general spent ones, excepting those that come directly against some considerable bone, etc." He goes on in another of his delightfully complicated sentences to describe his observations of bullets (or "balls" as he calls them) entering the skin of the chest obliquely and passing around the chest between the ribs and the skin due only to the resistance of the tough skin. It is not safe to assume, however, that a bullet that has apparently passed a distance through the chest or abdominal wall has not penetrated the pleura or peritoneum and then become superficial again. I recall being asked to see a

7. Ferguson, Ira: Personal communication.

8. Hunter, John: A Treatise on the Blood, Inflammation and Gunshot Wounds. p. 522. See citation No. 2.

boy, who while standing on the ground had been accidentally shot by a 22 calibre rifle fired from the window of a hay mow above him. There was a clean wound of entrance in the anterior chest wall. The bullet could be palpated under the skin of the abdomen to the right of and above the umbilicus. It might have been assumed that since the bullet entered almost parallel to the body surface, it had stayed superficial throughout its course. However, laparotomy revealed that the bullet had traversed the liver into the peritoneal cavity and then out to the surface. This incident brought to my mind the following case.

CASE TWO

A soldier had been hit in the right anterior chest by a German machine gun bullet. When we saw him at the field hospital, he had what looked like a minor grazing laceration of the chest wall. However, physical signs suggested peritoneal irritation. X-ray showed a bullet in the lower abdomen with its nose pointing upward. Laparotomy revealed that the bullet had passed through the diaphragm and liver, nicked the walls of the gall bladder and duodenum and come to rest among the coils of the small intestine.

Experience has taught that missiles can do severe damage, even beyond the point where they are found.

CASE THREE

A waist gunner was hit in the right buttock by what proved to be the detonator from a 20-mm. cannon shell fired from a German pursuit plane. He was admitted to an Evacuation Hospital in England and assigned to my operating team. He was severely wounded. Shock treatment had been started by a flight surgeon before he was removed from the aircraft and was continued while we took x-rays. The missile, which had entered through the right buttock, was located by x-ray in the pelvis a little to the left of the mid-line. The right ureter was surgically exposed and carefully examined because the course of the missile had been near to it. The ureter had escaped. The missile was found lying free in a rent in the meso-sigmoid, which was bleeding moderately. The rent was sutured and six perforations in the ileum found. One was repaired. As the others were well grouped, 18 inches of ileum were resected. His course was stormy for four days and then very satisfactory until the ninth day, when it was realized that his abdomen was filling with fluid. His intestinal tract had been functioning well and he did not show evidence of peritonitis. Paracentesis indicated that his peritoneum contained a large amount of urine. The ureters were catheterized and the abdomen x-rayed. This proved that the right ureter (which had been inspected at operation) was intact, but the left ureteral catheter was coiled up inside the abdomen. Left nephrostomy and ureterostomy was done and nephrectomy was required later because of sepsis. The detonator had obviously impinged the left ureter against the bony wall of the pelvis and bounced back to lie in the peritoneal cavity. Discovery of the ureteral injury at the first operation and catheter drainage might have saved the kidney. Bailey [9] says that injuries to ureters in war wounds are seldom recognized at operation because of the complicated conditions. We had at least thought of the ureter, but the wrong one.

TEAM WORK

MINOR injuries and many major injuries may be successfully handled by one interested and well trained physician; but he practically always needs some support. Team work in the care of the injured begins with first aid and transportation and continues long after the surgery is done, with attention to nutrition and an active program of rehabilitation. Boy Scouts, who occasionally do better first aid than doctors, Red Cross workers, members of ambulance squads and others who participate in the care of the injured should be recognized and made to feel that their efforts are appreciated. The certification of ambulance attendants has proved a valuable program in many communities. Curry [10] has described this program in Flint, Michigan. He has reported improvement in the immediate care and transportation of the injured since the program was adopted. The need for consultations has been repeatedly pointed out. General practitioners [11] have been advised to align themselves with general surgeons and other surgical specialists so that they will have available the support that they need when caring for severe injuries.

9. Bailey, Hamilton: Surgery of Modern Warfare. Vol. 1. p. 442. Cox and McDowell. Edinburgh 1942. Ed. 2.

10. Curry, George J.: Modern Medicine, 15:74 (Sept. 15, 1956)

11. Spencer, James H.: Bulletin of the American College of Surgeons, 39:119, 146 (May-June, 1954)

Surgical specialists must recognize their limitations and not hesitate to ask assistance from others. Many severely injured patients have multiple injuries that call for skills seldom possessed by one attendant. Kennedy[12] and his associates have called the multiple injury patient a team problem and have pointed out the necessity for a "team captain" who should have the authority to make all final decisions.

There is a trend today toward the organization of Trauma Services in large and medium-sized hospitals. On many of these services surgeons devote their entire professional interest to the care of the injured. These are not orthopedic services, although orthopedists play a big role in them. To be successful, they must have surgeons with diverse interests and skills, so that the multiple injury patient gets skillful attention to all his injuries. Curry[10] was one of the poineers in the organization of such a service at the Hurley Hospital in Flint. Snedecor[13] recently described the organization of such a service here in New Jersey. The work of his group is stimulating others to organize similar services.

Team work must continue into the period of rehabilitation. Valuable as departments of physical medicine are, the best rehabilitation takes place at home or back on the job. The patient's family must become part of the team in this phase of recovery. The convalescent should not be pampered, but should be encouraged to help with work around home. Employees are fortunate when they have employers who will allow them to return to work on graded jobs, fitted to their capabilities, until they are able to return to their former type of work. This is better for everyone concerned than having the victim of the accident sitting around the law courts waiting for an award. Fortunately some insurance companies and some members of the legal profession are accepting this point of view. In connection with injuries occurring in industry, it is interesting to note that after having the value of rehabilitation explained to them, some of the nation's top labor leaders are recognizing that this is far more important to the injured workman than high awards in the compensation courts. A sum of money may quickly disappear. A healthy body is a lifetime possession.

12. Kennedy, Robert H., Blum, Lester, Bryer, Ben F. and Payson, Benjamin J.: Modern Medicine, 16:110 (Feb. 1, 1957)

13. Snedecor, Spencer T.: Bulletin of the New Jersey Academy of Medicine, 2:14 (Dec. 1956)

49 High Street

Is Heat Dangerous in Shock?

A common first-aid for patients in shock is heat. This is condemned by Burton.* Indeed, for patients whose shock is due to blood loss, the application of heat, says Burton,* may have resulted in the unnecessary death of patients in shock.

The patient in shock feels cold because of the body's protective mechanism. Because of blood loss the body attempts to maintain normal blood pressure by reducing the flow of blood to those parts of the body where it is not needed most.

Application of heat to the feet or legs causes the flow in those parts to increase, dangerously dropping blood pressure and decreasing the flow of blood to the brain. This may result in death, Burton said.

The treatment for patients in shock caused by blood loss is transfusion or blood substitutes. Once that has been done it probably does not matter how hot the patient is kept.

*Burton, A. C., Canadian Medical Association Journal, 75:715 (Nov. 1956).

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Methitural as a Rectal Hypnotic in Children*

For children, a rectal thiobarbiturate offers a smooth induction with minimum emotional trauma. It is, however, a time-taking technic. Recovery time does not consistently vary with the type of barbiturate.

This study was designed to explore the usefulness of methitural sodium† as a rectal hypnotic in children. A preliminary study was carried out with 28 children to determine roughly the dose needed to induce sleep within ten minutes. It was felt that such a rectal hypnotic should be given in the operating room by the anesthetist. For this to be practical, the onset of sleep must be fairly rapid. The table below summarizes the results.

Subjects		Mean Dose Mg./lb.	Induction Time Minutes
15	Methitural†	24.4	6.3(5.0-7.9)
12	Thiopental§	17.9	5.1(4.2-6.3)

The doses of methitural† and thiopental§ were calculated on a milligram per pound basis and administered rectally as a 10 per cent solution. Induction time was measured from the moment the child was given the drug, until his eyes closed and the lid reflex was absent. With an average dose of 24.4 milligrams per pound of methitural,† the average induction time was 6.3 minutes. With an average dose of 17.9 milligrams per pound of thiopental,§ the mean induction time was 5.1 minutes.

A second series of cases was studied to construct a dose regression curve. A dose of each drug was chosen which was felt to be higher and lower than an optimal dose. The doses chosen for methitural† were 20 and 30 milligrams per pound. The doses chosen for thiopental§ were 15 and 25 mg. per pound. The induction times for each of these drug levels were recorded.

The induction time was plotted along the y-axis, the logarithm of the high and low dose of each drug was plotted along the x-axis. A dose of 17.7 milligrams per pound of thiopental§ or 28.4 milligrams per pound of methitural† would be expected to induce sleep in six minutes. The ratio of thiopental§ to methitural† at this level was 0.62. This figure indicates the ratio of dosage of a 10 per cent solution given rectally to produce a similar sleep time.

*Read May 1, 1957, at Atlantic City, before the Anesthesiology Section of The Medical Society of New Jersey. This work is from the Department of Anesthesiology of the Holy Name Hospital in Teaneck, N. J.

†The methitural was generously supplied by the Schering Corporation of Bloomfield, N. J., under their tradename of Neraval® Sodium.

§We used thiopental under its Abbott registered tradename of Pentothal®.

Information concerning the recovery time was also obtained from this series of cases. The twenty-four children were all candidates for tonsillectomy and all were premedicated with scopolamine. When the children were asleep, they were deeply anesthetized with Cyclopropane® and intubated orally. Anesthesia was maintained with a non-rebreathing valve of low resistance; the main agent was nitrous oxide supplemented with either trichloroethylene or Cyclopropane®. The duration of anesthesia was noted and the recovery time was measured from extubation to the time that the child responded to his name.

With a low dose of either methitural† or thiopental,§ the anesthesia and recovery time totalled thirty to eighty minutes; the longer the operating time, the shorter was the recovery time. With the high dose of either drug, the total anesthesia and recovery times were erratic.

The third series of children was studied with particular emphasis on decreasing the recovery time. Trousdell and Artusio [1] had mentioned the prolonged recovery time frequently found when using rectal thiopental.§ They suggested that this might be due to hypoxia. This third series of children was given a comparable dose of either methitural† or thiopental§ which would be expected to induce sleep in six minutes—28.4 milligrams of methitural† per pound, or 17.7 milligrams of thiopental§ per pound. Shortly after the Cyclopropane® was started, an intravenous dose of succinylcholine was given for intubation. The main agent was nitrous oxide supplemented with Cyclopropane®. One-half of the patients were given assisted respirations by pressing on the breathing bag during every other inspiration. These children, who had assisted respirations, were also extubed with succinylcholine to assure a minimal drop in oxygen saturation during extubation.[2]

The recovery time of the four groups of cases—that is with thiopental§ or methitural† with or without assistance was statistically analyzed by the ranking method of White.[3] This method does not involve any assumption that the distribution from which the samples are drawn is normal. Under these conditions, *there was no significant difference in recovery time between* methitural† compared to thiopental§ whether assistance was or was not given. The "average recovery" time is meaningless because of the same erratic behavior in some cases. A check was kept of a possible bowel movement during recovery. In general, children who had an involuntary movement during the early recovery period had a shorter recovery time; but many others, who had no involuntary movement, also had a short recovery time.

SUMMARY

THE usefulness of methitural† as a rectal hypnotic in children has been investigated. Thiopental§ was used as a control. A dose regression curve correlating the induction time in minutes compared to a high or low dose of both drugs has been constructed. A rectal dose of methitural† of 28.4 milligrams per pound is comparable to 17.7 milligrams per pound of thiopental§ and would be expected to induce sleep in six minutes.

During the construction of this dose regression curve, it was noted that the recovery times were erratic at the high dose level. This recovery time was investigated at the level of dosage estimated to induce sleep in six minutes. Again the recovery time was found to be erratic, some children sleeping a very long time. One-half of the patients were given assisted respirations during the anesthesia. There was no significant difference found in the recovery time between either of these four groups—no difference between methitural† or thiopental,§ with or without assistance to respiration.

1. Artusio, Joseph F., Jr., and Trousdell, Marjorie: Anesthesiology, 11:443 (July) 1950.

2. Lambie, Ronald S., and Pfaff, Frank: Anesthesiology, 17:47 (Jan.) 1956.

3. White, Colin: Biometrics, 8:33 (March) 1952.

CONCLUSIONS

1. The general advantages of a rectal thiobarbiturate previously reported for children have been corroborated in this study. The induction is smooth with minimal psychic trauma to the child.

2. The method, however, is time consuming. Average total time from the administration of the rectal medicant to the time the endotracheal tube was inserted averaged twelve minutes which includes waiting for the rectal medicant to cause sleep, the Cyclopropane® induction, giving the intravenous succinylcholine and inserting the tube. Some children complain of abdominal discomfort during induction. Many have an involuntary bowel movement even though they had an enema the evening before surgery.

3. This deals only with the use of the drug rectally and results cannot be extrapolated to other methods of administration.

718 Teaneck Road

Urinary Fluoride Levels Associated with Drinking Fluoridated Water*

Previous studies have demonstrated a close correlation between intake of fluoride naturally present in drinking water, and output of fluoride in the urine.

When sodium silicofluoride was added to the Montgomery County (Md.) water supply, the fluoride content of the urine reached that in the drinking water within 1 week, among 30 to 39 year-old males; and within approximately 3 years among 5 to 14 year-old males. When sodium fluoride was added to the Grand Rapids (Mich.) water supply, the fluoride content of the urine reached that in the drinking water within approximately 5 years, among 6 to 17 year-old males.

The difference in response of adults and children suggests that maturity influences the capacity of skeletal tissue to retain fluorides.

The results suggest no essential difference in urinary elimination of fluoride, between drinking water in which fluoride is naturally present and drinking water to which sodium fluoride or sodium silicofluoride has been added; and are regarded as evidence that no hazard of cumulative toxic fluorosis is associated with fluoridation.

*I. Zipkin *et al.*: Urinary Fluoride Levels Associated with use of Fluoridated Waters. Pub. Health Rep., 71:767 (Aug.) 1956.

Coronary Disease Among Women

A heavy increase in the incidence of acute coronary attacks in women, approaching that found in men, has been reported by Drs. Kyu Taik Lee and Wilbur A. Thomas, in the August 1956 *American Journal of Pathology* (32:653).

Findings from autopsy studies covering a 45-year period indicate a shift in the ratio of coronary heart disease between men and women.

Prior to 1940 the incidence of acute coronary attacks was twice as high among men as among women. Since 1940 the ratio has changed to one to one.

Two factors cited as of possible significance include: the great increase in cigarette smoking among women since 1910—and the increased numbers of women in older age brackets. Possibly there might be some correlation between acute coronary heart attacks and hormonal changes due to the menopause.

The authors noted that their data also were "compatible with the hypothesis that female hormones inhibit the development of arteriosclerosis, since they decrease progressively with age."

Acute coronary attacks in women continue to rise steadily in incidence with age, while the incidence in men becomes stationary in the age group 60 to 80 and then tapers off, the study revealed. Acute coronary attacks after 80 account for 30 per cent of the deaths in women but only 10 per cent of the deaths in men.

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Vitreous Implant in Retinal Detachment

REPORT OF TWO CASES

Heartening advances in the treatment of detachment of the retina have made this a less formidable disorder than it has ever been before. Dr. Spizziri and Dr. Atwood here describe the technic of treatment by vitreous implant.

Since the first description by Maitre in 1722 and Morgagni in 1740, retinal detachment has been one of the major problems in ophthalmology. The 1956 report by Shafer is one of the most heartening advances in the treatment of detachments since the work of Gonin.

The use of vitreous (from rabbits) was first attempted in 1895 by Deutschmann forty years after the first ophthalmoscopic description of retinal detachment. Other materials have been injected into the vitreous since then. The list includes: saline, air, cerebrospinal fluid and protein bodies. However, until the work by Shafer, treatment consisted of the classic diathermy primarily, and often one of the scleral shortening procedures. Results were often good. But the "chronic therapeutic failure" whose visual function and degree of detachment continually worsened despite repeated surgery, presented one of the most hopeless problems in ophthalmology. Now, however, as Case 2 below suggests, vitreous implant presents an encouraging outlook for at least some of these cases.

CASE ONE

A 62-year old woman had had an intracapsular cataract extraction with a peripheral left iridectomy in 1942. When corrected with a plus 14.00 plus 1.50x25, her left eye vision was 15/15-3. At that time examination was entirely negative except for cataract changes in the right eye, where uncorrected vision was 15/50. On November 11, 1954, the tension was found to be OD 17 OS 38 Schiotz. Gonioscopy revealed an open angle and fields showed constriction of the field OS to 20 degrees above, 40 degrees below and 30 degrees to each side. The tension was controlled by one drop of di-iso-propyl fluorophosphate every three days and the patient was asymptomatic until November 14, 1956. Then there occurred a spontaneous retinal detachment of the upper third with a tear nasally at 10 o'clock in the left eye. On November 21, 1956, a diathermy and vitreous implant† was done. As of March 18, 1957, the vision OS was 20/40 with a correction of +13.00 +2.00x30, and the tension was OD 18 OS 22 Schiotz.

CASE TWO

A 70-year old man was seen September 13, 1956. He gave a history of "smoky vision" in the left eye for a few days. Vision was OD 20/30, OS CF at one foot. He was found to have a total detachment especially in the superior nasal quadrant where the detachment was bullous. No holes were found. The detachment improved markedly with bed rest and on September 18, 1956, a diathermy was done with a lamellar scleral resection of one third of the circumference in the superior nasal quadrant. Postoperatively the retina was found to be reattached only to become redetached two weeks after surgery while still on complete bed rest. The redetachment was total. During the interim cataract changes occurred with vision reduced to light perception, and on November 11, 1956, a diathermy was done together with an external scleral buckle in the superior temporal quadrant and the implantation of vitreous. On December 26, 1956, he could count fingers at three feet, recognize faces and colors without his correction, and the retina was seen to be completely reattached. At this

†Human vitreous obtained postmortem and stored at ordinary refrigerator temperatures was used.

point, he had been ambulatory for over two weeks. Further follow-up was prevented by the patient's death from myocardial infarction, an occurrence completely unrelated to his surgery several weeks before.

These cases are felt to be of particular interest for several reasons. The first case demonstrates the safety of vitreous implantation in an eye with glaucoma and moderately severe field loss. The second case was unusual in that no tears were found even by indirect ophthalmoscopy. In this case, vitreous implant was combined with diathermy and a scleral shortening procedure with no deleterious effects to the eye.

Preoperative examination with the pupil widely dilated is an essential part of proper treatment, for unless all holes are found and sealed redetachment is likely. Adequate preoperative examination demands the use of indirect ophthalmoscopy preferably binocular. This takes at least an hour of such examination and often much more. Drawing of a picture or sketch of the fundus is an aid providing a perspective to the entire fundus picture as well as an accurate "memory."

In the technic of vitreous implant a number of important points present themselves. The first is the proper use of diathermy in closing all holes. This is greatly facilitated by "spotting" the holes with diathermy while visualizing the hole with the indirect ophthalmoscope. The hole can be localized by gently depressing the sclera with the electrode, then applying current when such depression is localized right over the tear itself. In this way the tear can then be easily surrounded with a sealing ring of diathermy. A second important point is proper placing of the sclerotomy for implantation of the vitreous. This is accomplished by scratching a partial or penetrating incision over the pars plana of the ciliary body just long enough to accept an 18 gage needle. The site of injection should be directly opposite the area of detachment and introduction of the needle must be accomplished carefully to avoid damage to the lens and retina or placement of the vitreous subretinally. Two opposing 0000 black silk or nylon monofilament* horizontal mattress sutures are placed in the incision. At the time of injection of the vitreous, counter traction is made in opposite directions on these sutures thus sealing the wound, to prevent loss of vitreous at the injection site. This counter traction is maintained throughout until these sutures are tied closing the wound. Actual injection of the vitreous is accomplished with an 18 gage needle and done slowly until the globe is firm but not hard; with the plunger of the syringe held in place, we wait at least a full minute to allow loss of subretinal fluid through previously placed drainage openings over the detached area. The globe will be seen to become softer. More vitreous is then implanted until the globe is again firm. The needle is withdrawn and the sutures tied. All the while, we maintain closure of the wound by counter-traction on the sutures as explained above. The sclerotomy area should be treated lightly with diathermy to form a seal around the hole made in the pars plana ciliaris.

Caution should be exercised in this maneuver as excessive diathermy here will pucker the wound and may actually open it with resultant leakage of vitreous.

As an alternative to scleral diathermy in this area, diathermy can be applied briefly directly to the shaft of the needle. This is done only after the needle itself is partially (almost completely) withdrawn from the eye, so as to avoid intra-ocular injury.

For best results (and to make the procedure technically easier) it is advisable to prepare the injection sclerotomy first while the globe is still firm; then the area of the detachment and all tears should be diathermied. Next drainage holes are made over the detached area and finally the vitreous itself implanted as described above.

SUMMARY

Two cases of retinal detachment successfully treated by implantation of vitreous are presented. Details of the technic are briefly discussed.

*We use the brand of nylon monofilament tradenamed Dermalon® by Davis and Geck.

400 Park Avenue

R. T. Forsberg, M.D.
W. O. Wuester, M.D.
F. M. Mastroianni, M.D.
Elizabeth

Partial Hepatectomy for Hemangioma of the Liver*

A surgeon may well go through a long professional lifetime without doing a partial hepatectomy. The organ is so vascular that any resection would seem to invite uncontrollable hemorrhage. The Wuester Clinic staff here points up a technic for partial hepatectomy with scanty blood loss.

Partial hepatectomy for hemangiomas of the liver has been reported in 85 cases. Most of these tumors occur in women. They usually involve the left lobe of the liver. In patients coming to surgery the age range was from 6 to 76 years. The larger proportion are in the 4th, 5th, and 6th decades of life. It is unusual for any surgeon to have more than one such case in his entire experience.

In one series of 71 cases, *symptoms* were noted in 55 cases. The most frequently reported symptoms are:

1. Symptoms of massive hemorrhage (spontaneous rupture)
2. Palpable tumor
3. Digestive disturbances
4. Vague abdominal discomfort
5. Asthenia and loss of weight
6. Hepatic colic type of pain

Except for the signs of hemorrhage, symptoms are usually attributed to pressure on the surrounding structures.

Correct *diagnosis* is made, in most cases, at operation. In over 80 per cent of the cases, a tumor mass is palpable. A blowing murmur over the mass and spontaneous changes in the volume of the tumor may lead the doctor to suspect the diagnosis. No laboratory procedures aid in definitive diagnosis, except by exclusion.

The following diagnoses have been made pre-operatively for what later was proved to be a hemangioma of the liver:

1. Hepatoma of the liver
2. Hydatid cysts of the liver
3. Pancreatic and mesenteric cysts
4. Gastric cancer
5. Hydrops of the gallbladder
6. Cholecystitis
7. Ptosed kidney or renal tumor
8. Appendicitis
9. Retroperitoneal tumor
10. Ovarian cyst

Most hemangiomata of the liver are thin-walled and of the cavernous type.

TREATMENT

Occasionally the initial symptom is spontaneous rupture. When rupture occurs, the results to date have been disappointing. In one

*Read by invitation before the New Jersey Society of Surgeons, Oct. 2, 1956.

reported series, 14 cases of spontaneous rupture occurred. Only 3 patients survived. The possibility of rupture is not remote and certainly is an important indication for treatment.

If acute or chronic symptoms occur, due to pressure from the mass, therapy should be instituted. The available treatment technics include:

Sclerosing solutions—This has proved successful in some situations. For very small lesions it is an impractical method, as clinical evaluation is obviously difficult.

Roentgen therapy—This has been tried both with or without Cushing Tubes. It has in some instances caused some reduction in the volume of the mass. It will not cure the tumor.

Surgery—By far the most successful approach has been surgical. The method offering the best result is partial hepatectomy.

Attempts to excise the lesion have brought dismay to the surgeon. It is difficult to delineate with accuracy the boundaries of the lesion. Uncontrollable hemorrhage is more likely to be encountered if the tumor itself is invaded.

If the tumor is not completely removed, recurrence is rather prompt. This is readily understood when one recalls the reparative ability of liver tissue, its vascularity and the vascularity of this particular neoplasm.

Reluctance to do hepatic resection stems from fear of hemorrhage during the procedure. Certain precautions can virtually eliminate this danger. If the usual pre-operative blood studies are normal, the danger of hemorrhage lies with the operating team. Care must be taken not to traumatize the tumor. This is easily obviated, provided that adequate exposure is obtained and gentle handling of the tissues is observed.

Hemostasis of liver tissue is effected by placing a row of ribbon gut sutures above the intended site of resection. With the use of the blunt needle and care in tying the sutures, very little bleeding will occur. Some surgeons have used the radiocurrent with equal success.

In the event of severe bleeding, packing the wound itself has usually led to fatality. By temporarily grasping the hepato-duodenal ligament, massive hemorrhage can be stopped. The availability of blood through our blood banks has aided in these emergencies.

If partial hepatectomy is employed, *prognosis* is excellent. We submit a case report of a successful partial hepatectomy.

A 57-year old woman came to the Wuester Clinic because of pruritis vulva. In the physical examination, a large, moderately mobile, asymptomatic mass was palpated in the right upper quadrant. The remainder of the physical examination revealed no abnormalities. Intravenous pyelogram showed a large, right-sided abdominal mass, apparently retroperitoneal, not of renal origin, but displacing the right kidney. A week later, the patient entered the Elizabeth General Hospital. At laparotomy, a 20 by 15 centimeter spongy hemangiomatous mass was found in the lower third of the right lobe of the liver. A smaller, similar lesion, 5 centimeters in diameter, was found above and lateral to the large mass. The gall bladder was normal, but contiguous with the involved tumor mass. The remainder of the exploration was normal. Because only 500 cubic centimeters of compatible blood were available, resection was deferred. A biopsy was taken with hemostasis easily effected and the report was cavernous hemangioma.

The abdomen was re-explored a month later. With 3 litres of blood available, partial hepatectomy was done as follows.

The abdomen was explored through a long right upper rectus splitting incision with lateral extension at the midpoint of the wound. The falciform ligament was divided, facilitating mobilization of the liver. Packing was placed above and posterior to the liver to elevate the liver into the wound. After packing off the intestines, the cystic duct and artery were exposed, divided and individually ligated. A row of mattress type ribbon gut sutures, 13 millimeters in width, on Hagedorn needles, were inserted into the liver substance 2½ centimeters above the limits of the tumor. The ribbon sutures were then tied and the liver divided 1½ centimeters distal to the row of sutures. The lower third of the right lobe of the liver with the gallbladder was resected. No bleeding of importance was encountered. Two pieces of Oxycel® were placed along the cut edge of the liver bed and secured over the raw surfaces with interrupted No. 3-0 chromic sutures. Two Penrose drains were placed near the liver and the abdomen was closed in layers. A half litre of blood was given at operation and the estimated blood loss was 200 cubic centimeters. Systolic blood pressure ranged between 70 and 120. Pulse range was 70 to 110. Postoperative course was uneventful. The drains were removed on the 10th postoperative day. The patient was discharged on the 12th postoperative day. She has been well since discharge. The drain sinus healed within three weeks. Liver function tests postoperatively were normal.

The pathologic report by Drs. J. P. Greeley and A. R. Casilli, was as follows: "The specimen con-

sists of a portion of liver with attached gallbladder, having a measured weight in its present fixed state of 426 Grams. The specimen has previously been sectioned and much of the sinusoidal blood released. It measured 15 by 11 by 5 centimeters. The major portion of the surface has a greyish-black, leathery appearance which is in sharp contrast to the adjacent gallbladder and apparently more near normal hepatic tissue. The sectioned surface shows a compressed periphery of greenish-brown hepatic tissue. In the center of this, there is a marked hemorrhagic spongy tissue which exudes blood on pressure. The surface of this latter has a mottled appearance from a bright red to dark blue in color. The gallbladder contains a thick pultaceous material. Microscopic examination revealed it to be a cavernous hemangioma of the liver associated with chronic periportal hepatitis."

On her last visit, 4½ years later, there was no evidence of recurrent disease.

SUMMARY

PRESENTED is a successful partial hepatectomy for a large cavernous hemangioma of the liver. The small blood loss and ease of removal following satisfactory precautions are stressed.

815 Salem Avenue

Tuberculosis Highlights

One-third of the people in the United States today are infected with live tubercle bacilli. For the first time in history, progress against tuberculosis has overshadowed the tragedy of the disease. The death rate has been reduced drastically—95 per cent since 1900, bringing it down to 10 per 100,000 population today. Yet—

Tuberculosis is still the giant among infectious-disease killers in this country, *killing more people than all other infectious diseases combined.* It is killing 45 persons a day, causing one death every half hour. Furthermore, the death rate is now levelling off.

Nearly 400,000 Americans are suffering from active tuberculosis today. 150,000 of these unreported to health authorities. Some 100,000 new cases of tuberculosis are being reported annually, at the rate of one every five minutes.

Between 50,000,000 and 60,000,000 people in this country are tuberculin reactors. Tuberculin skin sensitivity test shows that one third of the population is harboring the seeds of tuberculosis, that is, has been infected by tubercle bacilli but may not have active disease.

If the rate of break-downs with active disease among the infected continues as at present, then, 2,700,000 people who are tuberculin reactors today will have active tuberculosis during their lifetime.

Progress made in saving the lives of tuberculosis patients has been tremendous. Unfortunately, progress made in *preventing* tuberculous disease has been relatively slight.

Do Steroids Cure Hirsutism?

An effective approach to the problem of hirsutism in women is being developed, according to Dr. William H. Perloff, Temple University School of Medicine.*

Dr. Perloff* believes that hirsutism, common to certain races, especially those from the Mediterranean area, is associated with a selective adrenocortical dysfunction in which the production of masculinizing elements is inordinately increased.

Idiopathic hirsutism has been treated for 30 months at Temple University, "first with cortisone and later with prednisone after it was shown that this hormone had fewer side effects and is more potent than cortisone. Excessive hair also was removed by means of a wax depilatory. This procedure appears to shorten considerably the time required for clinical improvement of the hirsutes.

"In certain women a 'cure' apparently has been effected for as long as six months after the cessation of therapy." This is the longest period of time any one patient has been followed to date.

The ratio of androgenic to nonandrogenic steroids, as it exists in any one patient, may have deeper and more important implications. "One cannot help but wonder whether physical endurance, certain diseases with sexual predisposition, balding in men, psychosexual development and a host of other situations, may not somehow be influenced by the excretory pattern of the adrenal glands."

*Perloff, W. H.: Philadelphia Medicine 51:1477 (June 15) 1956

Announcements • • •

Obstetrical-Gynecological Meeting

On Wednesday, October 23, the N. J. Obstetrical and Gynecological Society will hold its semi-annual meeting at the Beth Israel Hospital, 203 Lyons Avenue, Newark. Gynecologic operations will be performed in the morning and there will be lectures in the afternoon. Also provided is a gallery of obstetrical and gynecologic exhibits, ample parking space for doctors, a bevy of beautiful usherettes and couriers, a message center for receiving and relaying your calls—and a hearty luncheon.

The exhibits will cover such topics as: vaginal cytology, sterility, endocrine advances, leucocyte-chromatin patterns, adrenalectomy for breast carcinoma, cardiac arrest, ovarian pregnancy, hysterosalpingography, the menstrual cycle, obstetrical anesthesia, postpartum rectal complications, postpartum hemorrhage and gynecography.

The afternoon program opens at 2 p.m. with case reports. Then follow three lectures. Dr. Louis Hellman will discuss obstetrical shock. Dr. Raphael Kurzrok will lecture on chemical tests for ovulation. And Dr. Henry Falk will talk on vesico-vaginal fistula. These papers will be open for discussion. The discussions will be led by Doctors Frank Hughes, James Leathem, Rita Finkler and Samuel Berkov.

For further details, communicate with the program chairman, Dr. John Huberman at 853 South Twelfth Street in Newark.

Seminar on Sex Offenders

On Wednesday evening, November 13 at 8:45 p.m. the MedicoLegal Society will hold a symposium on the sex deviate. This session is open to physicians and attorneys only. The meeting will be on the 3rd floor of the Rutgers University Law School in Newark at 37 Washington Street. The speakers will include Dr. Ralph Brancale, director of the Diagnostic Center and Deputy Attorney General Eugene Urbaniak.

Geriatric Symposium

On November 7 and 8 at the Waldorf Astoria Hotel in New York City, the American Geriatric Society, in cooperation with the AAGP, is offering a symposium on geriatrics for the practitioner. There are no fees and the AAGP gives credit for attendance. The Waldorf is at Park Avenue and 50th Street. For detailed program, write to Dr. Richard Kraemer, 2907 Post Road, Greenwood, Rhode Island.

Isotope Course

An intensive course in radioactive isotopes is offered by the New York University Graduate Medical School. It may be entered *the first of any month.*

Under the direction of Dr. Sidney Rubenfeld, the course will encompass complete physical aspects in instrumentation, and clinical application. Clinical work will include the diagnosis and treatment of thyroid cancer, blood volume determinations, red cell survival in the anemias, localization of tumors in the eye and brain, and the treatment with radioactive gold in the abdomen and chest. Tuition is $150. For information: The Associate Dean, Graduate Medical School, 550 First Avenue, New York 16, N. Y.

Epilepsy Treatment Reprint

The New Jersey Department of Health has available a limited supply of *The Drug Therapy of Epileptic Seizures.* It was a report to the Council on Pharmacy and Chemistry of the American Medical Association by Melvin D. Yahr, M.D., and H. Houston Merritt, M.D. You may get one copy gratis while the supply lasts. Write to Division of Chronic Illness Control, State Department of Health, Trenton 25, N. J.

Advanced Neurologic Training

The Public Health Service announces new financial support for training research scientists in the neurologic and sensory disorders. It is conducted by the National Institute of Neurologic Diseases, Bethesda 14, Maryland. It is focussed on training in either the clinical area or in such basic sciences as neurochemistry, neuropharmacology, neurophysiology or anatomy.

Awards will be made for one year periods subject to renewal and may be continued for three years. Stipends may range from $5,500 to $14,800 a year.

Application instructions may be obtained from the Extramural Programs Branch, National Institute of Neurological Diseases, Bethesda 14, Md.

Birthday Cake for V. A. H.

October 12th is the Fifth Anniversary for the Veterans Hospital at East Orange. During the past five years the staff of this 950 bed general hospital has treated 25,000 veterans. The hospital is administered by Dr. M. Herbert Fineberg, Manager.

The hospital has 1,080 employees of whom 56 are full-time physicians, with 22 residents, and 5 dentists. The visiting staff includes 44 consultants and 26 attending physicians, most of whom are members of The Medical Society of New Jersey. There are 4 dental consultants. More than 400 nurses and nursing aides staff the Nursing Service.

Residency training is fully accredited in internal medicine, general surgery, urology, pathology, radiology, physical medicine, neurology, pulmonary diseases and otolaryngology. The residency program is supervised by a committee consisting of Dr. Bernard J. Pisani, Chairman, Dr. Stewart F. Alexander, Dr. Charles L. Brown, Dr. Stuart Z. Hawkes, Dr. John F. Keating, Dr. Henry Kessler, Dr. Lewis Loeser, Dr. Merritte M. Maxwell and Dr. Allen O. Whipple. Dr. Milton I. Schwalbe, Director of Professional Services, is secretary of this committee.

The hospital's research program, which includes a Research Laboratory, is directed primarily towards problems affecting veterans. Particular emphasis at present, is being placed on cancer, blood dyscrasias, surgical procedures, tuberculosis and tranquilizing drugs. Work done in this hospital on cancer of the lung has attracted international attention.

Also working very closely with patients and their families are the Dietetic Service, a Medical Illustration Service, a Medical Records Library, Psychology Service, Social Work Service, chaplains of the major religious faiths, and Special Services. The latter supervises 550 regularly scheduled volunteers, who work in 19 different sections of the hospital, in addition to all of the wards.

Recreation and Library Service is provided for the patients, and an excellent Medical Library is maintained.

Jersey City Medical Program

The annual program of the Jersey City Medical Center Alumni will be held on November 8 and 9 this year at the Medical Center in Jersey City. The Friday morning program includes a symposium on the basic sciences by the faculty of the Seton Hall College of Medicine and Dentistry. On Friday afternoon there will be papers on intracardiac surgery, portal hypertension, bacterial endocarditis, oral surgery in cardiacs, and the treatment of apoplexy. At the Friday evening dinner, Hotel Plaza, Jersey City, the speaker will be Paul Dudley White, M.D. of Boston. The Saturday program is made up of departmental rounds, and open house.

For more information communicate with Samuel Cohen, M.D., 100 Clifton Place, Jersey City.

Obituaries • • •

DR. THOMAS S. BRADY

Dr. Thomas S. Brady, formerly assistant county medical examiner, died on July 6, 1957 at the age of 59.

A lifelong resident of Bayonne, he was graduated in 1919 from the Medical School at Fordham University. He returned to his native Bayonne and served the people of that municipality from 1920 until his retirement in 1954.

Dr. Brady at one time was police surgeon and for 20 years he was an assistant county medical examiner. He also had a tour of duty as fire department surgeon.

DR. WILLIAM W. HERSOHN

One of the leaders in New Jersey pathology, Dr. William W. Hersohn died after a coronary attack on July 17. Born in 1901, he was brought to Atlantic City at the age of 5 and attended the public schools here. After getting his baccalaureate degree at Rutgers he went to the Jefferson Medical College, receiving his M.D. in 1933. He interned at the Atlantic City Hospital, and then remained for an additional period as chief resident. He became increasingly interested in clinical pathology, and was a board diplomate in that specialty. From 1941 through 1945 he served in the Army as a pathologist and was a pioneer in developing mobile laboratories. He was a trustee of the Beth Israel Temple and a Fellow of the American Society of Clinical Pathologists. He did original research in the Rh factor. Dr. Hersohn was, for several terms, chairman of—and for 20 years a member of—the Scientific Exhibit Committee of The Medical Society of New Jersey.

DR. GERALD L. INFIELD

One of Atlantic County's civic leaders, Dr. Gerald Infield, died of a coronary occlusion on July 31. Born in 1906, he received a B.S. degree from the University of Pittsburgh in 1929 and his M.D. from Hahnemann in 1933. He saw active military duty from 1938 through 1942. In addition to a busy medical practice, Dr. Infield was a leader in a variety of community affairs. He was elected mayor of Northfield in 1948 and was consistently re-elected, holding that office at the time of his death in 1957. He was medical director of the Atlantic County Hospital, president of the Pleasantville Rotary Club and vice-president of the county League of Municipalities. He was also a cardiologist affiliated with the Shore Memorial Hospital.

DR. J. EUGENIA JACQUES

The state's oldest woman physician, J. Eugenia Jacques is dead. Had she lived an additional six days, she would have been 88 years old. She died of pneumonia following a chest injury 3 weeks earlier. Death took place on August 10. An alumna of the old Baltimore Woman's Medical College (class of 1897) she returned to her native city to intern at the Christ Hospital in Jersey City. She did general practice, and served as school doctor to several of the schools in Jersey City. When she received her automobile driver's license in 1902, she was said to be the first woman licensed to drive a car in Hudson County. In those days you had to crank them by hand! She never had a Cadillac. Last year she was cited by The Medical Society of New Jersey as one of the golden anniversary laureates.

DR. ARTHUR OWEN LARGAY

Born in Maine in 1892, Dr. Arthur Owen Largay died at his home in Bayonne on August 2. An alumnus of Georgetown (class of 1917), Dr. Largay first came to Hudson County in 1918 to serve an internship at St. Francis Hospital in Jersey City. He became interested in phthisiology and did graduate work in that specialty. He served in the Army Medical Corps in World War I, and was physician to several schools in Hudson County. He was affiliated with several hospitals in that county.

DR. WALTER F. LONGSHORE

At the untimely age of 49, Dr. Walter Longshore died of coronary occlusion on August 26. Dr. Longshore was assistant chief of radiology at the Martland Medical Center in Newark. He lived in Orange, where he was chairman of the Public Housing Authority. An alumnus of Howard University Medical School (class of 1930) Dr. Longshore interned in Washington, D. C. and then returned to his native Orange to practice. Some years

ago he was president of the Northern Jersey Medical Society. Dr. Longshore was also affiliated with several New York Hospitals, and was an alumnus of Bellevue's residency training program in radiology and roentgenology.

DR. JOSEPH H. ORAM

One of Paterson's senior practitioners, Dr. Joseph Hubbard Oram died on August 25. He was 81 years old. In 1899, Dr. Oram was graduated from the Jefferson Medical College, to which he later returned for some years as an instructor in surgical anatomy. Dr. Oram was a medical examiner for the Pennsylvania Railroad and was chief of a surgical service at the Paterson General Hospital. He was a past-president of the New Jersey Society of Surgeons and was also an F.A.C.S. Dr. Oram served the people of Passaic County for over 50 years.

DR. HENRY B. ORTON

One of the world's best known laryngeal surgeons, Henry Boylan Orton died on September 1. Born in Newark in 1886, he was the scion of a family with deep roots in New Jersey, a member of the Sons of the American Revolution. In 1908 he received his M.D. at the Jefferson Medical College. He did general practice until 1917 when he entered the medical corps of the Army. On being demobilized in 1919, he began graduate study of ophthalmology and laryngology, first in France, later in England. On returning to New Jersey, he limited himself to that specialty and soon won international recognition as a pioneer in major laryngological surgery and in technics of deep neck surgery. Eventually Dr. Orton won practically every honor in laryngeal surgery. He was one of the few New Jersey men to be national president of the A.C.S. He won awards from the American Academy of Otolaryngology, the Essex County Medical Society and the American Laryngologic Association.

Dr. Orton was professor of surgery at New York Polyclinic, a senior examiner of the American Board of Otolaryngology, and a past-president of the American Bronchoscopic Association. He was recognized as a key surgeon in advancing the whole field of bronchoscopy. He served as chief of laryngeal surgery or as consultant at almost every hospital in Northern New Jersey. He held every office in the American Laryngologic Association. This JOURNAL has published many of Dr. Orton's contributions

DR. RUBIN POLESHUCK

At the early age of 50, Dr. Rubin Poleshuck died of a coronary occlusion at his home on August 6, 1957. Born in Europe in 1907, Dr. Poleshuck was brought to the United States as a boy. He was graduated from the Rutgers College of Pharmacy in 1927 and after serving briefly as a pharmacist, he entered the Bellevue Medical College from which he was graduated in 1934. He was on the surgical staff at the Newark Beth Israel Hospital and was in private practice in Hillside. A Fellow of the International College of Surgeons, he was active in the affairs of the Temple Oheb Sholem in Newark. He was a member of the Essex County Anatomical and Pathological Society.

DR. STANLEY TESKEY

On August 30, Dr. Stanley Teskey of Bernardsville died after a short illness. Born in Toronto, Canada, in 1899, Dr. Teskey was graduated from the medical school there in 1929. He came to the Memorial Hospital in Morristown here to serve an internship, and decided to make our state and country his permanent home. He served the people of Morris County for more than a quarter of a century. He was, for a decade, a member of the Memorial Hospital's executive committee. He was director of the hospital's outpatient department. He was active in masonic and Rotary Club affairs and had a tour of duty as Bernardsville's Fire Department Surgeon. Dr. Teskey was an attending surgeon at the Memorial Hospital.

DR. PENROSE H. THOMPSON

Dr. Penrose Thompson died on July 25, after a brief illness. Born in 1904 he was graduated in 1929 from the Hahnemann Medical College in Philadelphia. He then made his home in Camden County and served the people of South Jersey for more than a quarter of a century. He was, at one time, president of the New Jersey Homeopathic Society. Dr. Thompson was active in the affairs of the Sons of the American Revolution. For 15 years he was police surgeon to Pennsauken Township. From 1929 to 1948 he was the township's school physician. For 27 years he was on the staff of the West Jersey Hospital.

County Society Reports • • •

Bergen

Approximately 150 of our members and guests gathered at Petrullo's Everglades Restaurant in Hackensack for the annual installation meeting of the *Bergen County Medical Society* on June 11, 1957. A social hour was thoroughly enjoyed and at 7:45 p.m. President Knight called the formal meeting to order. Guests included Harold R. Bernshock, Assistant Administrator of Hackensack Hospital; Dr. Harris K. Cohan, Administrator of Hasbrouck Heights Hospital; Henry Holman, President of Bergen County Health Association; Russell Mannino, President of the Bergen County Pharmaceutical Association; T. C. Menzenhauer, Society Auditor; Mort. L. O'Connell, President of Hasbrouck Heights Hospital; Charles Rais, Chairman of the National Foundation for Infantile Paralysis, Bergen County Chapter, Martin S. Ulan, Administrator of Hackensack Hospital and Paul Huckin, President of the Bergen County Bar Association.

Dr. W. H. Johnson, chairman of the Building Committee briefly described a plot in Teaneck, which the Building Committee has recommended that the Society consider purchasing as the site for a permanent headquarters. A vote clearly indicated a large majority in the affirmative.

The following were elected to membership: To Associate, Drs. Mary C. Googe and Rene R. Rohart; To Regular from Associate, Drs. Carol Shaw Hamilton, John W. McDonald and Tor Richter; To Regular from Associate as of July 1, 1957, Drs. June R. Flory, Waldo Greenspan, Herman Grossman, E. William Jewell, Dante H. Liberti, Robert L. Nutt and William C. Soule; To Regular by Transfer from County of New York, Drs. Charles J. Popovits and John D. Gossel; to Courtesy, Drs. Daniel L. Goldstein and Irwin L. Maskin; To Emeritus, Dr. William L. Vroom; To Honorary, Dr. Dickinson W. Richards, Jr.

Dr. Knight presented a Past President's Pin to Dr. John E. McWhorter after complimenting him on his administration during a year beset with several major problems.

The Chair then installed Dr. Fitzpatrick as the President of the Bergen County Medical Society for the year 1957-58 and presented him with the gavel.

After thanking Dr. Knight and acknowledging the responsibility of the office of the President which he was assuming, Dr. Fitzpatrick asked Dr. Knight to return to the roster and presented him with a Past President's Pin. He then presented to the meeting the following officers for the year 1957-58; First Vice-President, Dr. George Heller; Second Vice-President, Dr. Donald B. Hull; Secretary and Reporter, Dr. Charles P. Campbell; Treasurer, Dr. Frederick L. Muller and Assistant Treasurer, Dr. John P. O'Connor.

Following the adjournment, a buffet supper was served and during the evening entertainment was provided through the courtesy of Diaparene with Mr. George A. Tonak at the electric piano, assisted by Miss Jane Ritter and Mr. Bill Walker. A ladies chorus called "The Sweet Adelines" also entertained the members in a charming manner with various selections in close harmony.

CHARLES P. CAMPBELL, M.D.

Reporter

Monmouth

The annual outing of the *Monmouth County Medical Society* was held at the Deal Golf and Country Club on June 26, with Dr. William D'Elia as general chairman.

A pleasant afternoon of golf finished with Dr. John F. Stockfish winning the trophy for the low gross. Drs. Howard Pieper and Edward Salmeri tied for the low net. The Geri Trophy was won by Dr. Joel Feldman.

Dr. John Hardy, the outgoing president, received a gavel as a token of appreciation for the fine job he had done the past year. The presentation was made by the incoming president, Dr. Theodore Schlossbach.

The Society was honored by the presence of Dr. R. Browning Wilson, one of four members who have completed fifty years or more of medical practice. Also counted among the honored guests were the Honorable Richard Stout, State Senator; Mr. Theodore Parsons; Dr. Robert Lamb, President of the Monmouth County Dental Society; and James Thompson, President of the Monmouth-Ocean County Pharmaceutical Society.

The evening was concluded with a delicious steak dinner and an abundance of congenial convivialities.

DONALD W. BOWNE, M.D.

Reporter

Sussex

The annual meeting of the *Sussex County Medical Society* was held on May 7, 1957 at the St. Moritz at Sparta, N. J. Following a very fine roast beef dinner, the minutes of the previous meeting were read and approved.

Credentials committee reported favorably upon the application of Dr. Edwin M. Miller of Newton, N. J. Motion that he be accepted as a member of this society carried. The Society voted to authorize Dr. Lushear to approach the Branchville Business Mens' Club in regard to forming an exhibit at the

Branchville Fair in coordination with the Blood Bank Committee to the Medical Society.

The nominating committee submitted the following panel of candidates: Vice-President, John Schmidt; Secretary, Lucian Fletcher, Jr.; Treasurer, Lester Eddy; Reporter, Ed. Dailey; Delegate, Martin Kirschner; Alternate Delegate, Lester Vermes; Nominating Delegate, D. L. Spurgeon; Alternate Delegate, R. Weinstein.

The panel was elected and President Lushear took the chair.

J. E. LONGNECKER, M.D.

Reporter

Warren

The regular June meeting of the *Warren County Medical Society* was held at Warren Haven, our County Nursing Home. The members toured the home and most were agreeably surprised at the facilities afforded to patients and the quality of care.

The following officers for the coming year were installed: President—Carl A. Maxwell, M.D.; Vice-President—John Hampton, M.D.; Secretary—Ralph M. L. Buchanan, M.D.; Treasurer—Paul F. Drake, M.D.; Censors—N. C. Marlett, M.D.; Stanton Sykes, M.D.; J. J. McDonald, M.D.; Reporter — James H. Spillane, M.D.

The link of the town of Washington to the Red Cross Blood Bank program was discussed. It was suggested that general practitioners of the county meet to review the problem. The weekly report of Salk vaccine on hand, by physicians was reviewed by Dr. Buchanan.

A committee was appointed to arrange for an August social meeting. The next regular business meeting will be October 15.

The summer meeting of the *Warren County Medical Society* was held on Saturday, August 24, at the Harker's Hollow Country Club, near Phillipsburg. Thanks are due to Dr. Vincent Burell and Dr. V. Mereschak, for arranging and planning of the accompanying outing.

Interesting social events of the afternoon included swimming in the recently constructed pool, and a putting tournament for the doctors and their wives. After dinner there was a short talk by the president, Dr. C. A. Maxwell. Prizes were awarded by Dr. G. H. Bloom. Dancing followed and all had a very enjoyable evening.

JAMES H. SPILLANE, M.D.

Reporter

N. J. Gastroenterologic Society

The following officers were recently elected to the *New Jersey Gastroenterologic Society*:

Dr. Jacob A. Riese—President
Dr. Ferdinand Weisbrod—Vice-President
Dr. Abraham Friedman—Secretary-Treasurer

JACOB A. RIESE, M.D.

Reporter

Letters to The Journal • • •

Dear Editor:

Sometimes I think our dental colleagues are a lot smarter than we doctors of medicine. Not long ago I received my six month dental notice and failing to make proper contact within two weeks, received a follow-up call at the office. The voice on the phone was polite but firm. I was due—would I please come in? I promptly did, with an apology for disregarding the first reminder.

As it turned out I had no cavities and the only work was a routine dental prophylaxis and a vocal reminder to appear in six months. I left thinking my dentist a wonderful guy and very pleased with myself for having escaped so lightly. I recall paying the bill promptly and gratefully.

After all, here was a friend who guarded and cared for my teeth, and further, contacted me, all with unfailing regularity. Suddenly the answer seemed very simple. All my dentist had was a planned program. Further, my indoctrination and education to regular dental supervision had been so effective there was no thought of protest.

Amazing, isn't it, that we haven't applied the same philosophy to medicine?

ROBERT B. MARIN, M.D.
Montclair, N. J.

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Science Looks at Smoking. By Eric Northrup. Introduction by Harry S N. Greene, M.D., New York, Coward-McCann, Inc., 1957. Pp. 190. ($3.00)

Written by a well-known science writer for an interested and concerned public, this book poses a new inquiry into the effects of smoking on health. In recent year much publicity has been devoted to the proposition that cigarette smoking has a causal connection with lung cancer and cardiovascular disease. Mr. Northrup points out that although smoking *may* be a factor in these diseases, it is not definitely proved as yet.

The case for incriminating tobacco in lung cancer and heart disease rests primarily upon statistical studies, especially the American Cancer Society study of smoking habits and deaths among white males, and a similar investigation among British physicians. Competent scientists have criticized these studies on two major counts. *First,* there were errors in the design of research, especially in the American study where no effort was made to match the smokers and non-smokers in all respects other than smoking habits. *Second,* although statistical procedures can point to possible associations, these clues do not by themselves prove anything.

Causal relationship, moreover, is often difficult to establish with certainty. The famous Wynder-Graham mouse skin-painting experiment of several years ago, for example, remains one of the few successful attempts to induce cancer with tobacco products. The inability, however, of other scientists to duplicate this work in other strains of mice or in other animals generally, suggests that there may have been something peculiar about the Wynder-Graham mice.

In his introduction, Dr. Greene, pathologist of Yale University, reviews unanswered questions about the origin of cancer and the role of statistics in scientific proof. He states, "Lung cancer is a serious disease, and intelligent individuals will abstain from tobacco or any substance definitely known to be a causative agent. But assurance is needed that the substance blamed is actually cancer-producing and that the evidence brought forward is not colored by prejudice or overly enthusiastic intrepretation."

It is hoped that skeptical questioning on the part of the medical profession and general public in this current controversy will promote proper regard for valid scientific proofs in this and related matters of preventive medicine.

FRED B. ROGERS, M.D.

New and Nonofficial Remedies, 1957. By the Council on Pharmacy and Chemistry of the American Medical Association. Philadelphia, Lippincott, 1957. Pp. 582. ($3.35)

The shifting spotlight of medical care has for many years now returned to the use of drugs and this is reflected in the current issue of New and Nonofficial Remedies. This book includes drugs commonly available in the United States that have not previously been included in an earlier issue or in the *Pharmacopoeia.* The drugs are presented primarily under their generic names but the tradenames are also indicated after each entry. The Council on Pharmacy and Chemistry of the American Medical Association has written an evaluation of each drug, including a brief statement as to dosage, action and usage. There is a useful index at the end and a metric apothecary conversion table in the beginning. The drugs are grouped under broad headings such as analgesics, anesthetics and so on alphabetically to vitamins.

HENRY A. DAVIDSON, M.D.

Sick Children; Diagnosis and Treatment. By Donald Paterson, M.D. Ed. 7 revised by R. Lightwood, M.D. Pp. 593. Philadelphia, Lippincott, 1956. ($8.75)

In the preface of his first edition of *Sick Children* Dr. Paterson said that keeping in mind the need of the senior student and the general practitioner, his main stress has been on diagnosis and treatment as the surest way of making the manual practical and helpful. In the preface to the seventh edition, Dr. Lightwood reports that chapters 17 and 18 are entirely new, and that the chapter on history taking and clinical examination are virtually so.

The chapter on history taking and clinical examination is excellent, and the stress on disease is important. Where the manual falls short is in the lack of detail in treatment and up-to-date information. For instance, under the heading anorexia nervosa, mention is made of iron, vitamins and crude liver extracts. But an important statement is lacking, and that is that psychiatric appraisal and guidance are necessary in resolving the problem in the more severe cases.

Again in the treatment of pneumococcal meningitis the author states that penicillin is the drug of choice, given intramuscularly and intrathecally.

When the manual was published in 1956 the intravenous use of penicillin every 2 hours (1,000,000 units) for 3 to 4 days, then one million units every 12 hours was established as the desired way of giving penicillin in this disease. Further, sodium sulfadiazine (5 per cent solution) is readily given subcutaneously until sulfadiazine can be taken and tolerated by mouth. Intrathecal administration of penicillin is rarely advised after the initial injection. There are other examples of lack of explicit instruction. Even the senior student and the general practitioner want to know the most up-to-date method of drug administration for a particular disease.

Immunization against tetanus, diphtheria, and pertussis is mentioned under prophylaxis of each respective disease. The efficient immunization procedure of giving D.P.T. in combination is not mentioned. The method (D.P.T. in combination) was well established before this book was published in 1956.

The manual *Sick Children* needs a great deal of "up-to-date" revision if it is to serve the purpose the authors intended.

WILLIAM F. MATTHEWS, M.D.

The Road to Inner Freedom: The Ethics. Baruch Spinoza. Dagobert Runes, Ph.D., Editor. New York, 1957, The Philosophical Library. Pp. 209. ($3.00)

Spinoza's *Ethics* is one of the most influential books of the western world. From that work, Dr. Runes has extracted some passages, translated them and strung them together like beads on a rope. Somewhere between the original and this version, the words seem to have lost much of their power. It is hard to believe that the cliches assembled here once made an impression on the world's greatest philosophers.

ULYSSES FRANK, M.D.

The Riddle of Stuttering. C. S. Bluemel, M.D. The Interstate Publishing Company, 1957. Danville, Illinois. Pp. 142. Hardbound $3.50. Paper bound $1.50.

It is surprising how little the medical profession has contributed to the treatment of speech defects. Most of the advances have been made by speech correctionists, psychologists, special therapists and, above all, the patients themselves. In this text, Dr. Bluemel accepts the concept that stuttering is a neurotic phenomenon. However, he rejects psychodynamic and psychoanalytic explanations, suggesting that stuttering develops because of incoordinate neuromuscular reactions, or under the impact of stress. His treatment regime is aimed first at the sensory rather than the motor end of the chain. He exposes the subject to good speech, has him first "think" the words silently, then whisper them. He thus gradually induces the patient to articulate fluently. He finds that many stutterers will do well if alone, and he uses telephone equipment, blindfolds and tape recorders to get the subject to speak while alone. Both group and individual therapy are detailed. The thesis is interesting and the instructions are explicit enough to permit the therapist to try Dr. Bluemel's methods. A set of phonograph records (at $3 a disc) is also available. All proceeds from the sale of the records or from the sale of this book have been assigned to the American Speech and Hearing Foundation.

HERBERT BOEHM, M.D.

Gynecologic Therapy. William Bickers, M.D. Pp. 158. Springfield, Illinois, Charles C. Thomas, 1957. ($4.25)

This complete survey of gynecologic therapy is written in a somewhat different pattern. Each condition is described from the clinical viewpoint and treatment of each is given immediately following each. Almost every condition likely to be encountered in gynecologic practice is dealt with. The index is complete, but the systematic way in which the subjects are anatomically discussed almost makes it unnecessary. The concise and non-superfluous methods used in treating each subject, make the reader feel he is getting the real "meat" out of each page. Each subject is headed in bold type so that the reader can swiftly find what he wants.

The book was written primarily for interns and residents as a handy, rather complete ready reference. It will certainly be of value to any general practitioner and also to the gynecologist in his relationship to his interns and residents.

VICTOR HUBERMAN, M.D.

Atlas of Clinical Endocrinology. By H. Lisser, M.D. and Roberto F. Escamilla, M.D. Pp. 476, St. Louis, C. V. Mosby, 1957. ($18.75)

This book is replete with photographic illustrations of the leading endocrinopathies, gathered by authorities who have a wealth of information and experience in this field of medicine. The topics are well organized and individual entities can be readily located. Typical case histories are presented, and along with the visual approach, the test stresses diagnosis (including the necessary laboratory routine) and therapy. These are adequately presented in concise outline form.

Details of physiology, chemistry, and pathology are not found in this collection. This is rather a book with a clinical approach to endocrinology, and would be of value to any physician or surgeon, who is likely to be confronted with problems of an endocrine nature. I recommend this as an excellent addendum to a doctor's library.

ETHEL G. LAWNER, M.D.

TUBERCULOSIS Abstracts

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Vol. XXX October, 1957 No. 10

Advantages of Hospital Admission Chest X-ray Examinations

By Abraham Melamed, M.D., The Journal of the American Medical Association, March 2, 1957.

● For many reasons routine hospital admission chest x-ray examinations should be required and performed in all hospitals. There are advantages to the patient and hospital personnel resulting from such examinations. Such examinations represent an integral part of, and advanee, in up-to-date hospital and medieal care.

Routine hospital admission chest x-ray examinations are performed in only 21 per cent of all hospitals in the United States according to the 1954 figures of the American Hospital Association. It is difficult to comprehend the reason for such a situation when the advantages of such examinations were demonstrated as long as 20 years ago. For many reasons chest x-ray examinations should be a necessary and integral part of a patient's studies in the hospital.

Communicable Diseases.—Routine chest x-ray examination of the hospital population is important to all hospital personnel and to their families. The incidence of tuberculosis and other respiratory diseases is said to be greater among hospital personnel than among workers in any other industry. In any hospital chest x-ray program preemployment and at least *annual* chest x-ray examinations of employees are essential. The making of *semi-annual* chest x-ray films of those on the attending and house staffs is also inherent in such programs.

Errors in Diagnosis of Chest Diseases. — The value and necessity of admission chest x-ray examination were demonstrated over 20 years ago when it was proved that, as a group, the physicians at the University of Michigan Hospitals committed one gross error a day without the benefit of such chest x-ray films. This demonstration in itself warrants the adoption of routine admission chest x-ray examination of all hospital patients.

Unsuspected Cases of Chest Disease. — Many unsuspected cases of chest disease amenable to treatment are uncovered by admission chest x-ray examination. Prompt treatment of these patients decreases morbidity and mortality rates and the length of hospitalization. In this day of high hospital costs and shortages of hospital beds the latter consideration is not a minor one.

Pre-operative Work-up.—In the evaluation and preparation of the surgical patient, the routine admission chest radiograph furnishes information of value to surgeons and anesthesiologists. The correlation of the physical findings with the x-ray findings increases the accuracy of the appraisal of the patient's cardiopulmonary status and often influences the choice of the anesthetic agent and type of surgical procedure.

Record of Chest Condition. — In everyday roentgenography of the chest, we are faced with the problems of ascertaining, if possible, the acuteness or chronicity of thoracic abnormalities. Many such questions can be resolved promptly and easily if previous chest films are available for comparison. Admission chest x-ray films provide such valuable records, particularly in patients with postoperative and other types of thoracic complications. X-ray diagnosis of chest disease is thus made more reliable and accurate.

Life History of Disease.—Over 20 million patients are admitted to hospitals annually. Chest x-ray examination of all such patients would not only provide information of immediate importance to the patient but also valuable data for the study of the natural history of many chest diseases. The potentialities of the use of such data in the study of primary cancer of the lung has been demonstrated.

Compensation and Accident Cases.—In accident and compensation cases, as in other types of

medical practice, negative and positive findings are of equal importance. The availability of a routine roentgenogram provides essential data for the treatment of the patient and in the consideration of compensation claims. Unsuspected traumatic lesions of the chest and adjoining tissues which may not produce immediate symptoms are not infrequently uncovered by admission chest x-ray films.

Trauma to other parts of the body may often be suspected or indicated on the basis of intrathoracic changes. For example, basilar atelectatic foci might reflect injury to intra-abdominal and/or diaphragmatic structures.

Teaching Program in General Hospitals.—Survey chest x-ray films provide the members of the house staff with an opportunity to become acquainted with the appearance of the average or "normal" chest film, and provide a check on the physical findings. From such correlations the house staff members learn the limitations of the various forms of examination and the indications for further x-ray investigation. A chest x-ray admission program may help to make the hospital an educational center for detection, diagnosis, treatment and even follow-up of chest diseases.

Routine Hospital Examinations.—Chest x-ray screening of hospital patients reveals significant positive abnormalities in 10 to 15 per cent of patients. Granted that the presence of many of these abnormalities is suspected, but the severity or extent of disease and/or reactivation of previous disease is very often unsuspected. The percentage of significant positive findings disclosed by admission chest x-ray examination is greater than that revealed by any other routine hospital laboratory procedure.

Detection of Tuberculosis.—The great strides made in the treatment of tuberculosis have given us a false sense of security and have resulted in erroneous conclusions. Although the death rate from tuberculosis has fallen precipitously, the case rate in most areas has shown no corresponding or significant change. In the state of Wisconsin, for example, there has been only a slight decrease since the advent of therapy with streptomycin sulfate. Many studies have shown that the yield of tuberculosis among hospital patients is two to eight times greater than that found in mass surveys. Ill patients entering general hospitals are more likely to have more advanced forms of tuberculosis. Tuberculosis is overlooked more frequently in hospital patients over the age of 50 years than in those under the age of 40 years. One authority has emphasized the necessity of examining the aged—"the neglected seedbed of the tubercle bacillus."

Diseases Other Than Tuberculosis. — Diseases other than tuberculosis are found in 80 to 90 per cent of the patients in whom there are significant positive findings in hospital admission surveys. Many great vessel and cardiac abnormalities are found in hospital chest x-ray surveys. The presence of some or most of these lesions is previously suspected, but in many patients the severity of the condition is underestimated. The number of patients in whom heart disease is detected is at least four times the number of those in whom tuberculosis is found.

Diaphragmatic abnormalities and changes in the lungs due to atelectasis as revealed on admission x-ray films often provide early clues to intra-abdominal disease although primary intrathoracic disease may be responsible for the symptoms. When portions of the upper extremities and lower neck are included on admission chest minifilms, it is not unusual for unsuspected lesions in these areas to be detected.

The results of chest x-ray surveys for the detection of curable cancer of the lung have been disappointing. The poor results are not to be attributable to the x-ray method but more to the lack of appreciation and delineation of the x-ray signs of early cancer of the lung. Unfortunately, when the x-ray evidence is characteristic, cure is almost impossible.

Attention must be focussed on asymptomatic patients if we are to make any significant advance in the treatment of this disease. Surveys yield impressive dividends when abnormal shadows of any kind are suspected of indicating carcinoma in men over the age of 45. X-ray evidence of lung cancer is present in the average case for more than 24 months before the diagnosis is established. It is possible to detect the presence of cancer earlier if our suspicion is aroused by any unexplained pulmonary abnormality.

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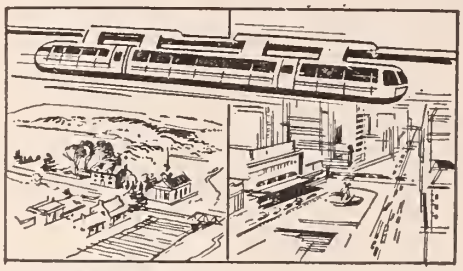


Normal glomerulus, showing arteriole musculature, glomerular epithelial podocytes, and "epitheloid" muscle cells of vas efferens.

1. Settel, E.: Rolicton® (Aminoisometradine), a New, Nonmercurial Diuretic, Postgrad. Med. *21*:186 (Feb.) 1957.
2. Assali, N. S.: Personal communication, May 28, 1956.

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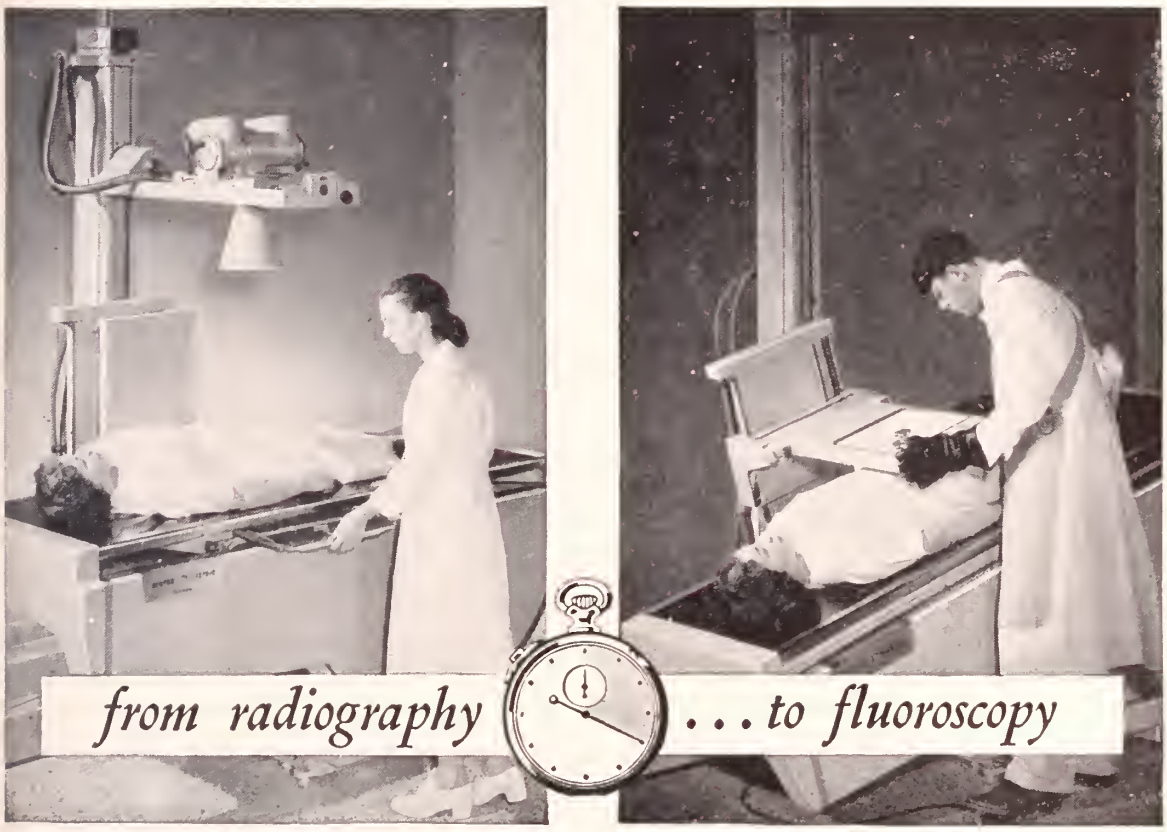
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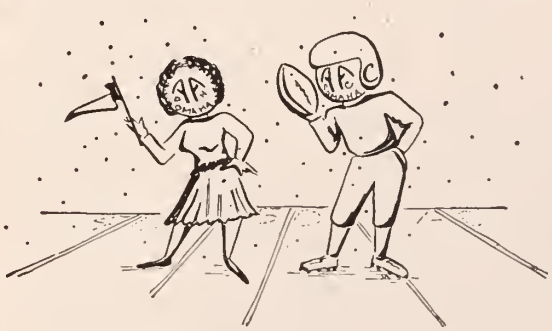
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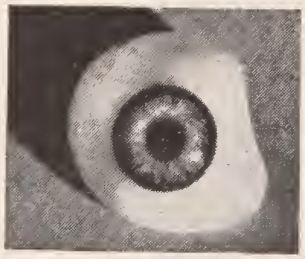
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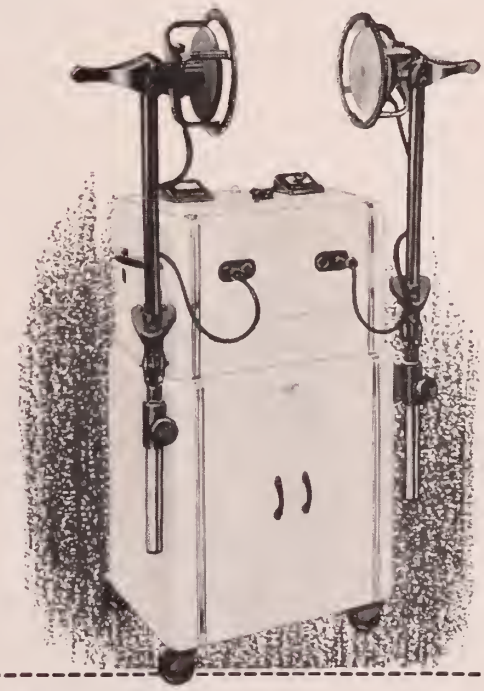
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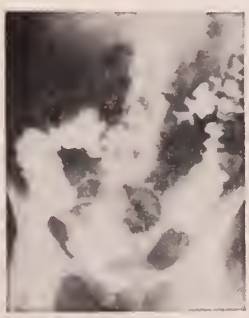
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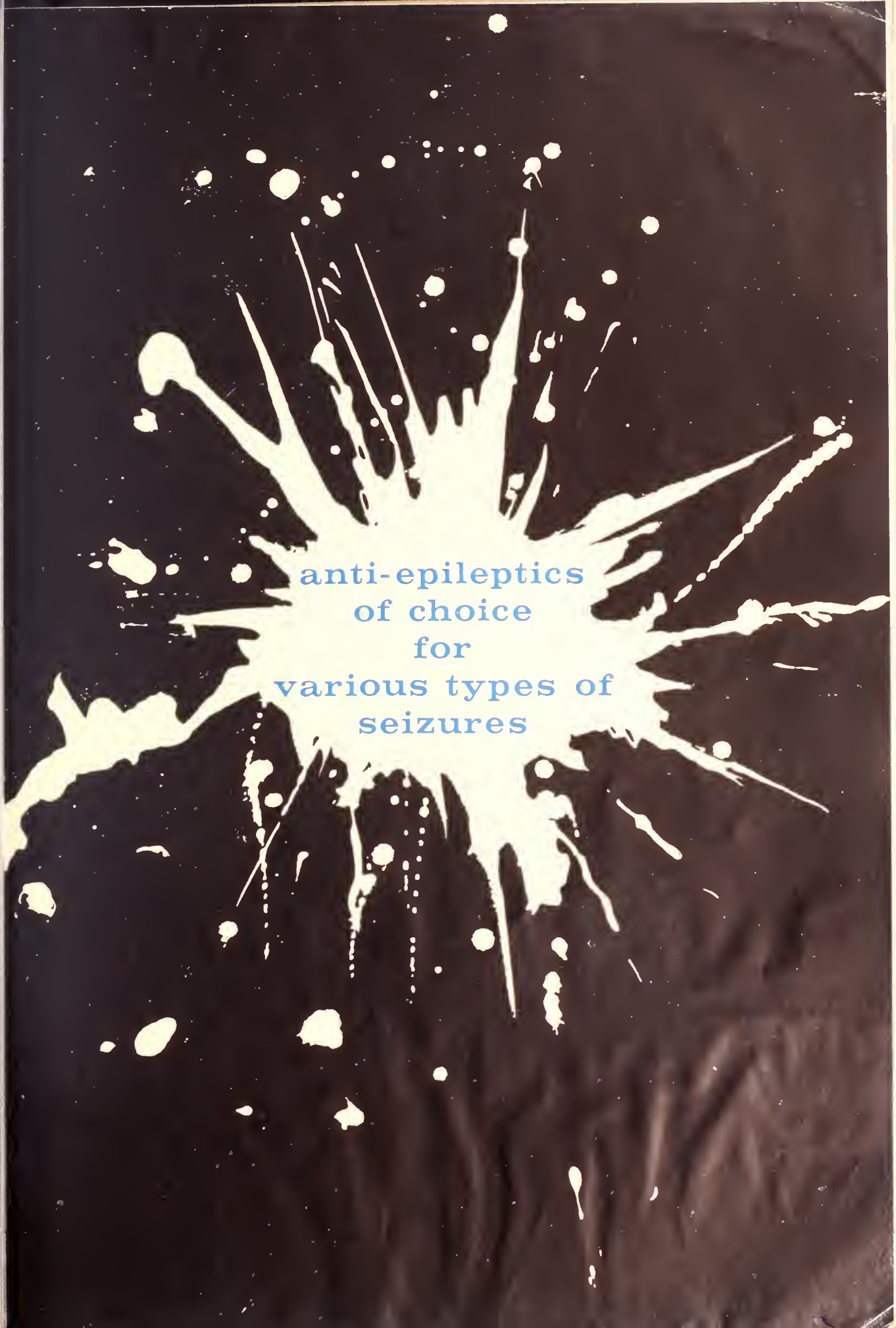
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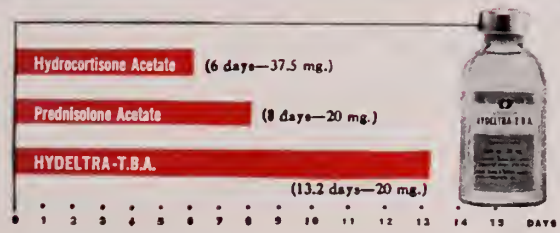
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8 STUDENTS ON FLIGHTS TO U.S. HAVE ASIAN FLU

New York, Aug. 15 (AP) Laboratory tests on e foreign exchange student arrived Aug. 8 show they victims of Asiatic flu, the health department repo today. The eight arrived plane from Europe.

Twenty-nine other stud suffering from influenza rived Tuesday from Rot dam on the ship Arosa Sky. One, Nicholas Memmos, Greek exchange student, die yesterday. Six of these stu dents were released today the others are to be re tomorrow. It has not termined whether died from Asiatic

Pea vac izat flov the ority States

THE INFLU
How Deadly Will i
What Can We Do

IF
Ans
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—is s
arour
now

The War on Mutant A

If Florence was in the grip of an epi-demic of colds, coughs and fevers, astrolo-gers . . . declared that it was caused by the influence of an unusual conjunction of planets. This sickness to be known as "infl

—Chronicles of 1200-1470.

To combat new r luence," a worldwide his week in respons rom the Far East. Si s the World Health eva, which collects i rom around the globe pecimens of the ene ions. In more than a ncluding those of th

Asian Flu: the Outlook

Asian influenza will hit the U.S. this fall before mass immunization can be effective, and the nation faces an epidemic which may strike 15 million to 30 million people. The disease is relatively mild (in no way comparable to the killing "Spanish flu" of 1918-19), and is likely to cause only a small number of deaths among the feeble young and enfeebled old. But it may compel 10% to 20% of the population in affected areas to tak thus

W quie a co pect Ser pop

U.S. Fighting A

The War On Asiatic Flu

There's cause for concern about Asiatic flu, but scientists and public health officials see no reason for anyone to panic.

First shipments of the vaccine against the new influenza strain have arrived in Chicago, setting off a flood of telephone calls from worried patients to doctors, and from doctors to drug suppliers. This is a nor pattern of mass fear and is understan

The of the

Even though Salk vaccine priorities were necessary, the regulation produced administrative headaches, public complaints and probably a gray, if not a black market. When regulation i invoke it. would

PUBLIC HEALTH

Influenza

➤ INFLUENZA, one of the m dictable of communicable disease ing "on cat feet" across the na now. It has already struck once in mild epidemic form at an base in Colorado. When and ho it will strike again is a perennia public health authorities.

to counteract
complications from

"ORIENTAL FLU"

UEMIC
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ATCH "ASIATIC" FLU—

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filmtab®

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STEARATE (Erythromycin Stearate, Abbott)

effective against staph-, strep- and pneumococci

Abbott

when a cold takes hold
counteract all the symptoms

To curb and control even the severest cold symptoms, CORICIDIN® FORTÉ Capsules offer the combined benefits of clinically proved CORICIDIN—plus—

methamphetamine —to counteract depression and fatigue
vitamin C —to meet added requirements during stress of illness
antihistamine —in full therapeutic dosage

CORICIDIN FORTÉ provides comprehensive therapy not only to counteract congestive and coryzal symptoms of the severest cold but also to combat lassitude, fever, aching muscles, torpor, depression and general malaise.

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CB-J-7107

for certain disorders of menstruation and pregnancy

TRULY EFFECTIVE PROGESTATIONAL THERAPY **BY MOUTH**

NORLUTIN

T.M.

(norethindrone, Parke-Davis)

***oral* progestogen**
with
unexcelled potency
and
unsurpassed efficacy

Now, with small oral doses of this new and distinctive progestogen, you can produce the clinical effects of injected progesterone. In amenorrheic women for example, "As little as 50 mg. of [NORLUTIN] administered in divided doses over a five-day period was sufficient to induce withdrawal bleeding."[1]

CASE SUMMARY[2]

Amenorrhea of 4 years' duration in a 24-year-old married woman. A course of 10 mg. NORLUTIN twice daily for 5 days was followed after 3 days by menses lasting about 5 days. Since no spontaneous menstruation occurred during the following 35 days, she was given another course of treatment with NORLUTIN, 10 mg. twice daily for 5 days. This was followed by menses.

When this patient was given ethisterone, 40 mg. twice daily for 5 days, no bleeding had ensued when she was seen 41 days later.

INDICATIONS FOR NORLUTIN: conditions involving deficiency of progestogen such as primary and secondary amenorrhea, menstrual irregularity, functional uterine bleeding, endocrine infertility, habitual abortion, threatened abortion, premenstrual tension, and dysmenorrhea.

PACKAGING: 5-mg. scored tablets (C. T. No. 882), bottles of 30.

REFERENCES: (1) Greenblatt, R. B.: *J. Clin. Endocrinol.* 16:869, 1956. (2) Hertz, R.; Waite, J. H., & Thomas, L. B.: *Proc. Soc. Exper. Biol. & Med.* 91:418, 1956.

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INTRAVENOUS Compatible with commor IV fluids. Stable for 24 hours in solution at room temperature. Aver age IV dose is 500 mg. given at 12 hour intervals. Vials of 100 mg., 250 mg., 500 mg.

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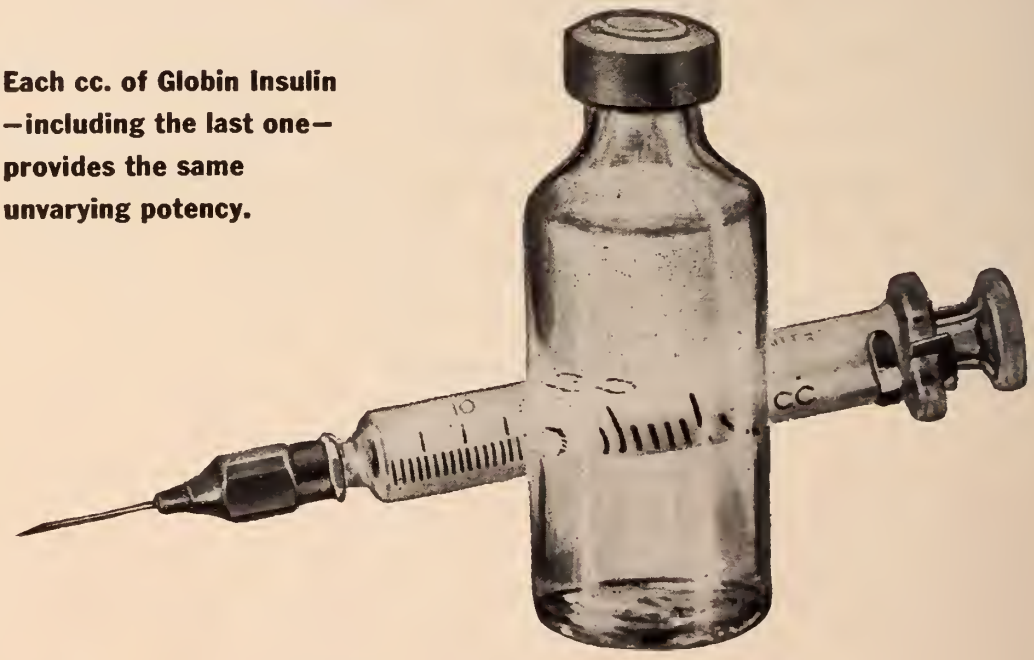
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ver a wide variety of infections -
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STURDY CONSTRUCTION . . . prevents damage in shipping. Modern design and distinctive color of box make it easily identified.

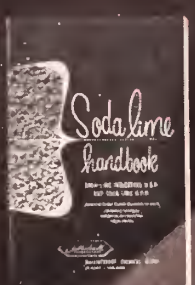
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New Chemotherapy

ARALEN® *in* RHEUMATOID ARTHRITIS

Extensive studies of rheumatoid arthritis and related collagen diseases—in this country and abroad—have shown the antimalarial Aralen phosphate to be highly effective and well tolerated in a large percentage of patients.

Clinical Results with Aralen in Rheumatoid Arthritis

Author	No. of Cases	Major Improvement	Minor Improvement	No Effect
Haydu[1]	28	22	5	1
Rinehart[2]	25	12	4	9
Freedman[3]	50	43	3	4
Bagnall[4]	108	77	12	19
Bruckner[5]	36	32	0	4
Cohen and Calkins[6]	22	17	3	2
Scherbel et al.[7]	25	9	8	8
Total	294	212 (72%)	35 (12%)	47 (16%)

- Success dependent upon persistent treatment
- Often of benefit where other agents have failed
- Remissions on therapy well maintained
- Remission of 3 to 12 months possible even if treatment is interrupted
- Tachyphylaxis not evident

GENERAL EFFECTS:

- Patient feels better
- Patient looks better
- Exercise tolerance increases
- Walking speed and hand grip improves

LABORATORY EFFECTS:

- E. S. R. may fall slowly
- Hemoglobin level may gradually rise

ANALGESICS AND STEROIDS:

- Requirements usually reduced or eliminated

JOINT EFFECTS:

- Pain and tenderness relieved
- Mobility increases
- Swellings diminish or disappear
- Muscle strength improves
- Rheumatic nodules may disappear
- Even severe or advanced deformity may improve
- *Active* inflammatory process usually subsides
- Joint effusion may diminish

DOSAGE:

Aralen is cumulative in action and requires four to twelve weeks of administration before therapeutic effects become apparent.

Latest information indicates that an initial dose of 250 mg. of Aralen phosphate is preferred to the higher doses sometimes recommended. However, if side effects appear, withdraw Aralen for several days until they subside. Reinstate treatment with 125 mg. daily and, if well tolerated, increase to 250 mg. The usual maintenance dose is 250 mg. daily.

New Chemotherapy

INDICATIONS:

- Rheumatoid arthritis, acute or chronic —with or without adjunctive therapy.
- Spondylitis
- Arthritis associated with lupus erythematosus or psoriasis

THEORY OF ACTION:

Aralen appears to suppress or induce remission of rheumatoid inflammatory processes by inhibiting adenosinetriphosphatase.

HOW SUPPLIED:

Aralen phosphate: 250 mg. tablets in bottles of 100 and 1000.
125 mg. tablets in bottles of 100.

Tolerance:

Aralen is usually well tolerated. Toxic effects are usually mild and to date have been transitory in nature, disappearing completely either on continuance or cessation of therapy or on reduction in dosage.

Gastrointestinal disturbances (e.g. nausea, rarely vomiting, diarrhea, abdominal cramps, anorexia) are frequent manifestations of intolerance. Temporary blurring of vision (due to interference with accommodation) is also relatively frequent.

Pleomorphic skin eruptions (e.g. lichenoid, maculopapular, purpuric), although generally mild, may preclude the use of an optimum dosage schedule. If a skin reaction persists on a reduced dosage schedule, or recurs after reinstitution of treatment with gradually increasing doses, discontinue Aralen till the lesion again disappears and consider resuming treatment with Plaquenil® (brand of hydroxychloroquine).

Less frequently transitory vertigo, headache, lassitude, or neurological disturbances, such as nervousness, irritability, emotional change, and nightmares have been reported. Instances of unexplained slight gradual weight loss as the patient's general health and arthritic condition improved have been mentioned. Occasional instances of bleaching (depigmentation) of the hair have been described.

Although an occasional instance of leukopenia, with normal differential count, has been reported (WBC about 3000), it has not proved troublesome because it has always been reversible on discontinuance, or diminution of the dose. Even spontaneous reversal may occur while full dosage is maintained.

Caution:

Aralen is known to concentrate in the liver and, although hepatic damage has never been reported, the drug should be used with caution in the presence of liver disease. In the presence of severe gastrointestinal, neurological, or blood disorders, the drug should be used with caution or not at all. If such disorders occur during the course of therapy, the drug should be discontinued. Concomitant use of gold or phenylbutazone with Aralen should be avoided because of the tendency of these agents to produce drug dermatitis.

Clinical Comments:

Of fifty patients receiving Aralen therapy, "42 have become really well; that is, they have no stiffness, and any pain that occurs can reasonably be attributed to use of joints affected by secondary degenerative changes. They have no evidence of joint inflammation, but may have a raised erythrocyte sedimentation rate. They have little or no need for analgesics."
Freedman[3]

"One hundred and twenty-five private patients have been carefully followed clinically and haematologically while receiving well over 200 patient-years of chloroquine [Aralen] therapy. The results are considered good in 70%, one-half of these cases being in remission. Improved work performance, sedimentation rate, and hemoglobin levels paralleled the major objective gain in this 70%. 90% of them remained on chloroquine [Aralen] therapy, half for more than two years. Classical peripheral rheumatoid arthritis, spondylitis, arthritis of juvenile onset, and rheumatoid disease with psoriasis, all appeared to respond about equally well.

"It is suggested that chloroquine comes closer to the ideal for long-term, safe, control of rheumatoid disease than any other agent now available."
Bagnall[4]

"Out of the 36 rheumatoid arthritis cases we treated . . . favorable results were obtained in 32 cases.
Bruckner et al.[5]

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Extensions can be ordered with **CUT-OFF SWITCHES** to eliminate bell ringing in sickrooms.

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many patients with **MILD** involvement can be effectively controlled with

'MEPROLONE'

many patients with **MODERATELY SEVERE** involvement can be effectively controlled with

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NEW

and **NOW** for patients with **SEVERE** involvement

MULTIPLE COMPRESSED TABLETS

'MEPROLONE'

The first meprobamate-prednisolone therapy

the one antirheumatic, antiarthritic that simultaneously relieves: (1) muscle spasm (2) joint inflammation (3) anxiety and tension (4) discomfort and disability.

SUPPLIED: Multiple Compressed Tablets in three formulas: 'MEPROLONE'-5—5.0 mg. prednisolone, 400 mg. meprobamate and 200 mg. dried aluminum hydroxide gel. 'MEPROLONE'-2—2.0 mg. prednisolone, 200 mg. meprobamate and 200 mg. dried aluminum hydroxide gel. 'MEPROLONE'-1 supplies 1.0 mg. prednisolone in the same formula as 'MEPROLONE'-2.



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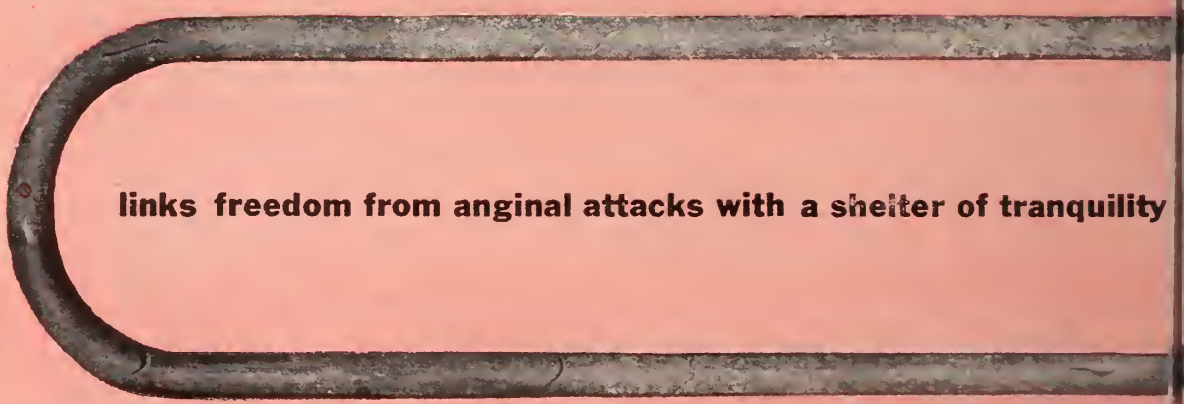
"the value of analgesic and tranquilizing agents should be clearly recognized in the management of [angina]..."[1]

new for angina

PETN + ATARAX

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CARTRAX*



links freedom from anginal attacks with a shelter of tranquility

In pain. Anxious. Fearful. On the road to cardiac invalidism. These are the pathways of angina patients. For fear and pain are inextricably linked in the angina syndrome.

For angina patients—perhaps the next one who enters your office—won't you consider new CARTRAX? This doubly effective therapy combines PETN (pentaerythritol tetranitrate) for lasting vasodilation and ATARAX for peace of mind. Thus CARTRAX relieves not only the anginal pain but reduces the concomitant anxiety.

Dosage and supplied: begin with 1 to 2 yellow tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. This may be increased for maximal effect by switching to *pink* tablets (20 mg. PETN plus 10 mg. ATARAX). In bottles of 100.

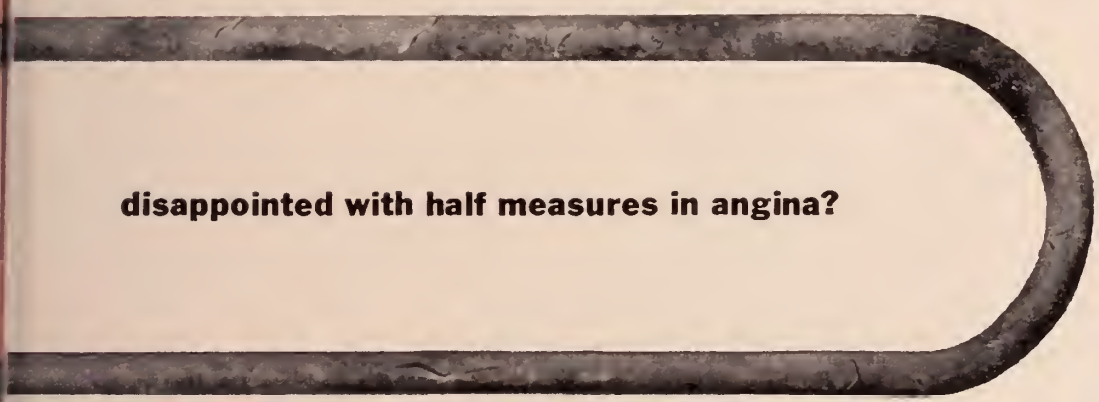
CARTRAX should be taken *before* meals, on a *continuous* dosage schedule. Use with caution in glaucoma.

1. Russek, H. I.: J. Am. Geriat. Soc. *4*:877 (Sept.) 1956.

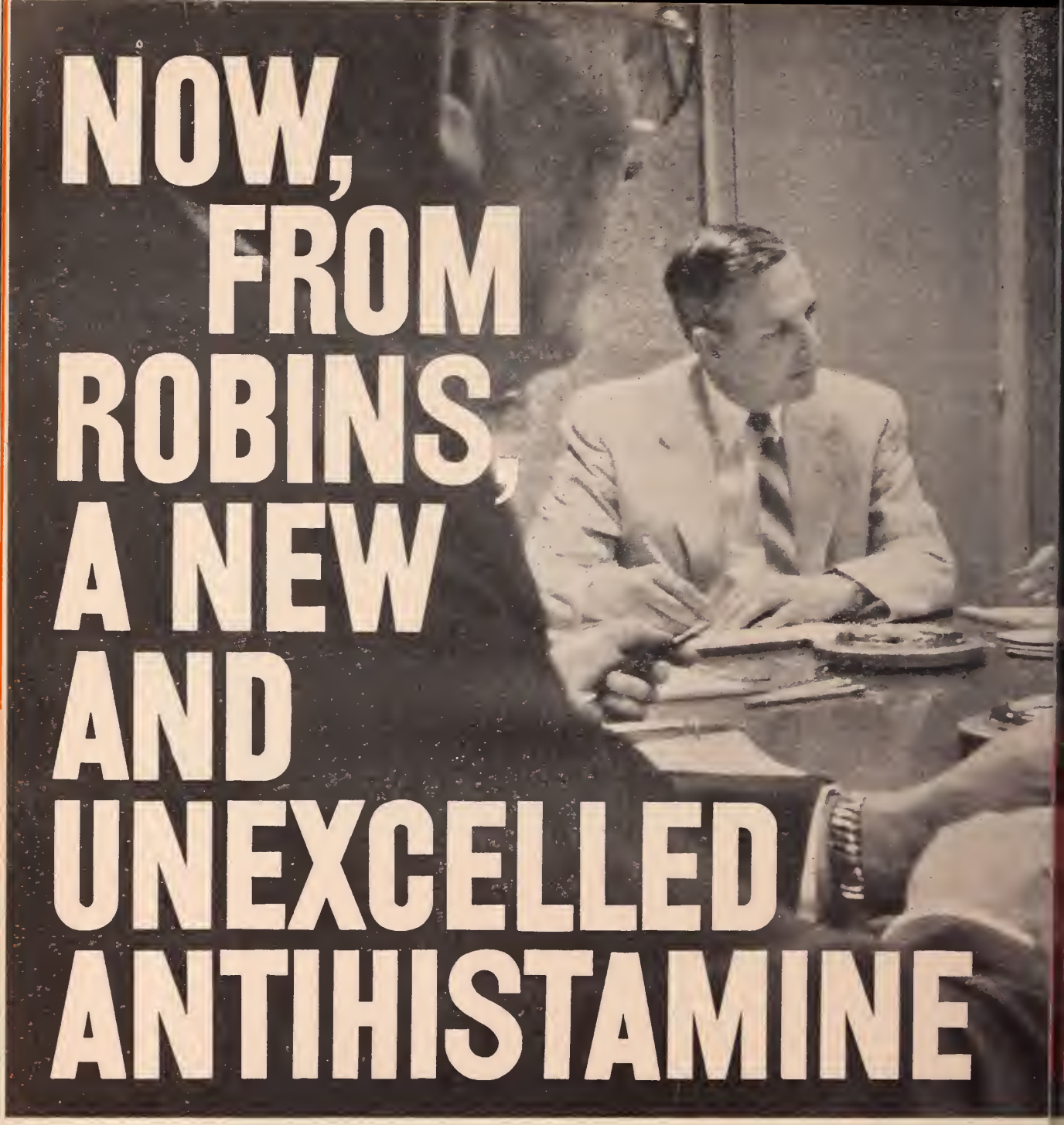
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» unexcelled antihistaminic action

Diagnosis	No. of Patients	Response				Side Effects
		Excellent	Good	Fair	Negative	
Allergic rhinitis and vasomotor rhinitis	30	14	9	5	2	Slight Drowsiness (1)
Urticaria and angioneurotic edema	3	1	1	1		Dizzy (1)
Allergic dermatitis	2		1	1		Slight Drowsiness (1)
Bronchial asthma	1		1			
Pruritus	1		1			
Total	37	15	13	7	2	Drowsiness (5) 14 Dizzy (1)

From the preliminary **Dimetane Extentabs** studies of three investigators. Further clinical investigations will be reported as comp



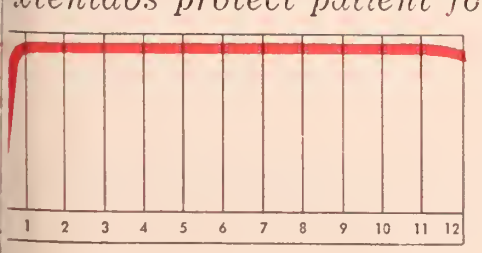
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Periods of stress can be easily handled with supplementary DIMETANE Tablets or Elixir to obtain maximum coverage.

Dosage:

Adults—One or two 4-mg. tabs. or two to four teaspoonfuls Elixir, three or four times daily. One Extentab q.8-12 h. or twice daily.

Children over 6—One tab. or two teaspoonfuls Elixir t.i.d. or q.i.d., or one Extentab q.12h.

Children 3-6—½ tab. or one teaspoonful Elixir t.i.d.

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My patients complain that
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***Why not try the new analgesic
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You mean something that
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It not only works in 5 to 15 minutes but
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Lipo Gantrisin
for infections
in children —

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provides therapeutic blood levels of time-proved Gantrisin around-the-clock—with only two doses daily

DESCRIPTION:

Lipo Gantrisin should be considered for use in many systemic and urinary tract infections because it provides:

1. the time-proved wide-spectrum antibacterial action of Gantrisin in a stable, free-flowing homogenized emulsion
2. convenience of therapeutic blood levels for 24 hours with just two daily doses
3. delicious taste that assures wide acceptance by children and adults
4. no need for forced fluids . . . no danger of renal blocking or secondary fungus growth

INDICATIONS:

Systemic and urinary tract infections due to streptococci, staphylococci, pneumococci, H. influenzae, K. pneumoniae, meningococci, E. coli, B. proteus, B. pyocyaneus, A. aerogenes, B. paracolon and Alcaligenes fecalis.

DOSAGE:

Children:	teaspoonfuls every 12 hours
20 lbs	1
40 lbs	1½
60 lbs	2
80 lbs	3
Adults:	4

CAUTION:
The usual precautions in sulfonamide therapy should be observed.

SUPPLIED:

Lipo Gantrisin Acetyl, containing 20 per cent Gantrisin (1 Gm per 5 cc in the form of Gantrisin Acetyl), in a palatable, readily digestible homogenized emulsion that prolongs the action of the drug. In bottles of 4 and 16 oz.

Lipo Gantrisin™ Acetyl — brand of acetyl sulfisoxazole in vegetable oil emulsion

ROCHE

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Feeding Newborns

Successful infant feeding depends on effective planning of the newborn's nutritional regimen. The first feeding, 12 hours after birth, may consist of a prelacteal solution of KARO® Syrup. This should be offered in one or two ounce amounts at two hour intervals for 24 to 48 hours to fulfill the high water requirement during the first week of life. Breast feeding may be initiated on the second day for five minute intervals to obtain colostrum and stimulate breast secretion. However, the prelacteal feeding is continued thereafter and between nursings.

Artificial feeding is offered on the second day if breast feeding is denied. Small infants are fed at three hour intervals and large infants at four hour intervals. The initial formula usually is a low caloric milk mixture to enable gradual adaptation of the feeding to the infant's tolerance. Concentration of the formula is gradually increased at intervals of several days, in the absence of digestive disturbances. The infant should be fed in a semi-reclining position, burped during and after feeding, and kept on his right side or abdomen undisturbed for an hour.

The same problems of infant feeding recur from generation to generation, but solutions may differ with each era. The carbohydrate requirement for all infants is as completely fulfilled by KARO Syrup today as a generation ago. Whatever the type of milk adapted to the individual infant, KARO Syrup may be added confidently because it is a balanced mixture of low molecular weight sugars, readily miscible, well tolerated, palliative, hypoallergenic, resistant to fermentation in the intestine, easily digestible, readily absorbed and non-laxative. It is readily available in all food stores.

℞ **FIRST FORMULAS FOR NEWBORNS ADAPTED ACCORDING TO TOLERANCE**

FORMULA I .....11 cals./oz.
*Whole Milk ..... 8 oz.
Water .....12 oz.
Karo .....½ oz.
3½ oz. x 6 q 4h.

FORMULA I .....12.5 cals./oz.
**Evap. milk ..... 4 oz.
Water .....14 oz.
Karo .....½ oz.
3½ oz. x 6 q 4h.

FORMULA I .....11 cals./oz.
Dried milk .....4 tbsp.
Water .....20 oz.
Karo .....½ oz.
3½ oz. x 6 q 4h.

FORMULA III .....16 cals./oz.
Whole milk .....10 oz.
Water .....10 oz.
Karo ..... 1 oz.
3½ oz. x 6 q 4h.

FORMULA III .....20 cals./oz.
Evap. milk ..... 6 oz.
Water .....12 oz.
Karo ..... 1 oz.
3 oz. x 6 q 4h.

FORMULA III .....18 cals./oz.
Dried milk .....6 tbsp.
Water .....20 oz.
Karo ..... 1 oz.
3½ oz. x 6 q 4h.

FORMULA II .....13.5 cals./oz.
Whole milk ..... 9 oz.
Water .....11 oz.
Karo .....¾ oz.
3½ oz. x 6 q 4h.

FORMULA II .....16 cals./oz.
Evap. milk ..... 5 oz.
Water .....13 oz.
Karo .....¾ oz.
3 oz. x 6 q 4h.

FORMULA II .....14.5 cals./oz.
Dried milk .....5 tbsp.
Water .....20 oz.
Karo .....¾ oz.
3½ oz. x 6 q 4h.

*Whole lactic acid milk formulas may also be prepared from whole cow's milk.

**Whole lactic acid milk formulas may also be prepared from evaporated cow's milk.

Adapted from Nelson's Pediatrics, Saunders, Phila. 1954

MEDICAL DIVISION
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NEW DOSAGE

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Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

[1] Nichols, R. L. and Finland, M.: J. Clin. Med. 49:410, 1957.

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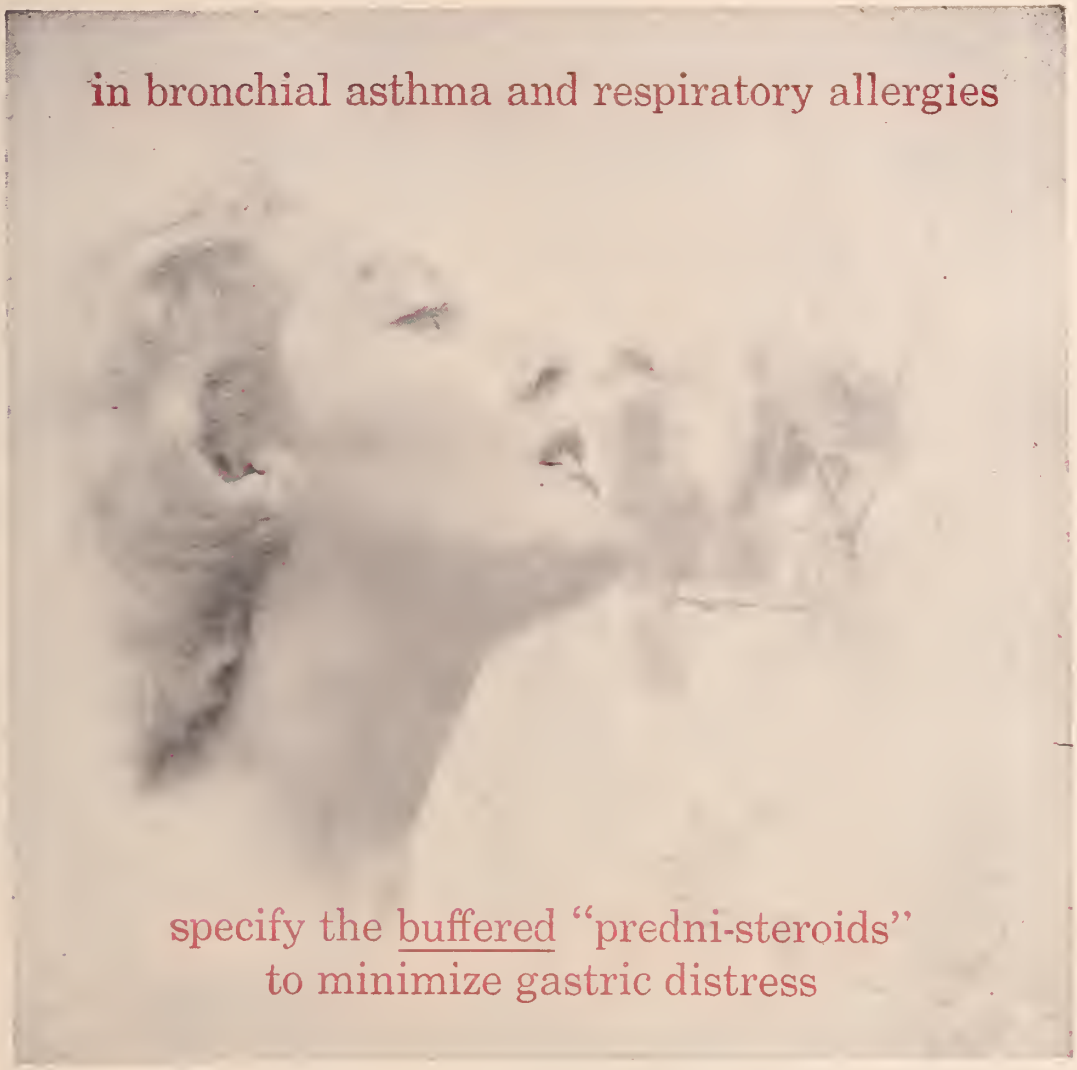
The easy digestibility of meat is a prime requisite of foods specified for the patient with congestive cardiac disease.

In addition to these important features, meat contributes other nutritional factors essential in any convalescence —the B vitamins thiamine, riboflavin, niacin, pantothenic acid, B_6, and B_{12}, and the minerals iron, phosphorus, potassium, and magnesium.

1. Odell, W. M.: Nutrition in Cardiovascular Disease, in Wohl, M. C., and Goodhart, R. S.: Modern Nutrition in Health and Disease, Philadelphia, Lea & Febiger, 1955, p. 699.
2. Bills, C. E.; McDonald, F. G.; Niedermeier, W., and Schwartz, M. C.: Sodium and Potassium in Foods and Waters, J. Am. Dietet. A. *25*:304 (Apr.) 1949.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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unexcelled in
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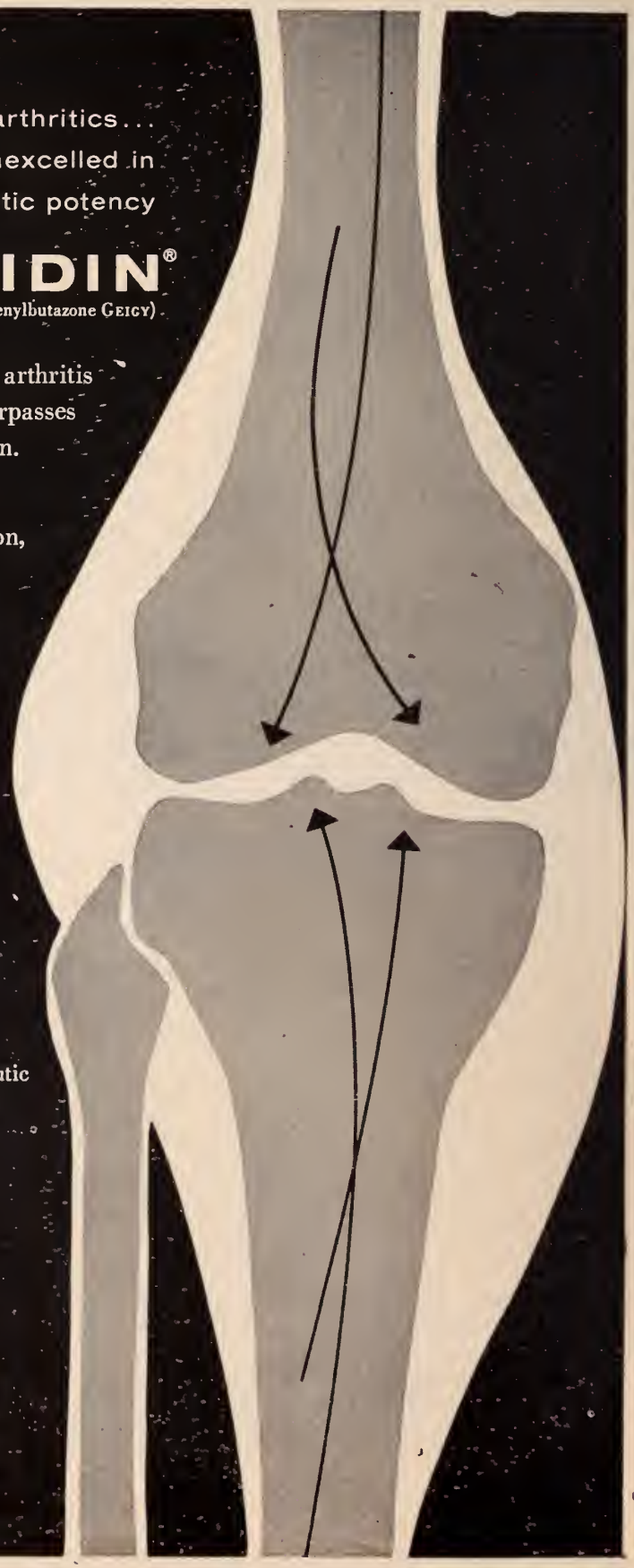
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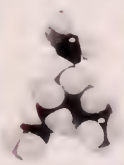
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2-methyl-2-**n**-propyl-1,3-propanediol dicarbamate — U. S. Patent 2,724,720

Supplied: 400 mg. scored tablets
200 mg. sugar-coated tablets

Usual dosage: One or two 400 mg. tablets t.i.d.

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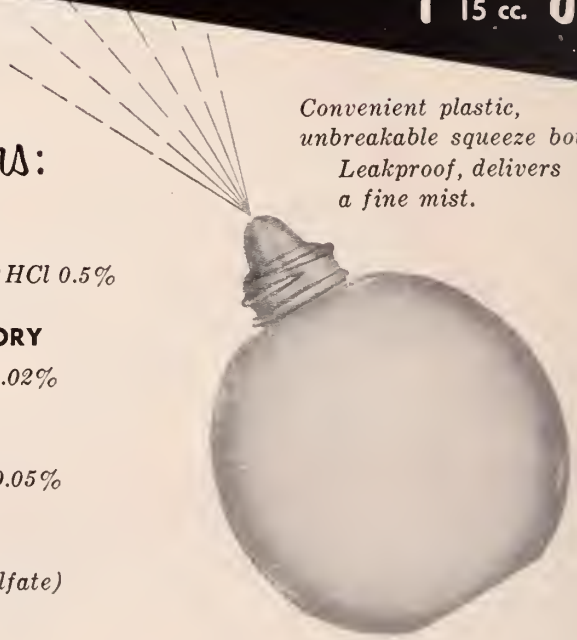
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an antipruritic
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providing an immediate sense of well-being

indications:

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Cervicitis – subacute and chronic

Pruritus Vulvae – hot pack applications

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Hygienic Irrigations – postcoital, postmenstrual

suggestion:

Upon retiring, a TRICHOTINE douche followed by a VACID suppository provides maximum effectiveness and 24-hour pH control.

The TRICHOTINE formula contains sodium lauryl sulfate, sodium perborate, sodium borate, thymol, menthol, eucalyptol and methyl salicylate.

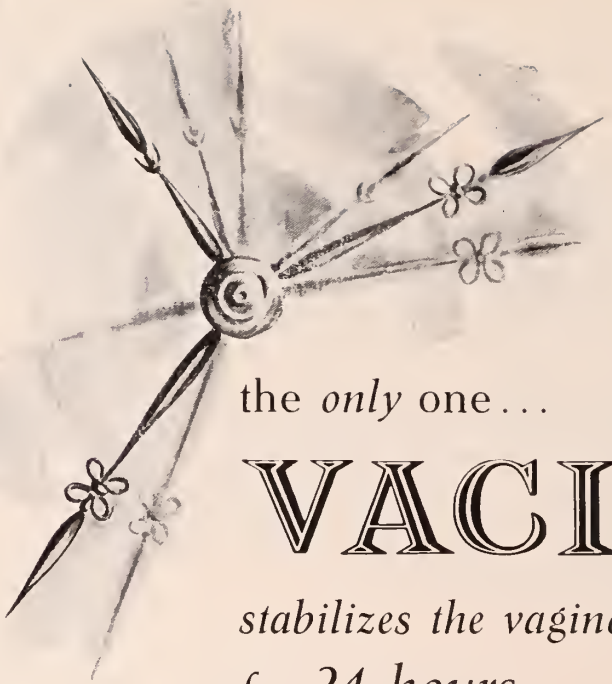
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CERVICITIS – subacute and chronic, including eversions

POSTCAUTERY and **POSTCONIZATION**

PREGNANCY and **POSTPARTUM** – prophylactically and in infections.

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FORMULA – Each Vacid suppository contains a high capacity polyacrylic cationic exchange resin (activated and buffered) combined with lactose.

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Robins

Pabalate with Hydrocortisone

Clinical evidence indicates that, in Pabalate-HC, the synergistic antirheumatoid effects of hydrocortisone, salicylate, para-aminobenzoate, and ascorbic acid achieve satisfactory remission of symptoms in *up to 85% of cases studied*

—*with a much higher degree of safety*

—*even when therapy is maintained for long periods*

—*at significant economy for the patient*

Each tablet of Pabalate-HC contains 2.5 mg. of hydrocortisone — 50% more potent than cortisone, yet not more toxic.



FORMULA

In each tablet:

Hydrocortisone (alcohol)	2.5 mg.
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Potassium para-aminobenzoate	0.3 Gm.
Ascorbic acid	50.0 mg.

DOSAGE: Two tablets four times daily. Additional information on request.

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frozen shoulder

Bursitis and tenosynovitis are new terms to homemakers, but they are not uncommon sequels to overexertion. Early antirheumatic therapy is to be encouraged in the treatment of these conditions, as it is in more serious rheumatic conditions, to alleviate pain and prevent progression of the disorder. With adequate therapy the prognosis of bursitis in its acute stage is good. Delaying therapy may result in extension of the inflammation and gross anatomical changes that tend to incapacitate the patient.

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Dosage: The usual adult dose is 250 mg. every six hours.

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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

The Ultimate Tranquilizer

More than 100 fine pharmaceutical houses make drugs for administration to human beings. A few years ago, only three or four companies were making tranquilizers. These products were quite successful — as measured by the company's profits—so other manufacturers tried to share in the tranquilizer market. One of the beauties of our American free enterprise system is that competition spurs each manufacturer to make something a little better. If the drug has too many side-effects, a competitor strives mightily to develop a drug with fewer, or milder, untoward effects. If too large a dose is required, another competitor aims at a concentrated form of the drug so that the dose may be reduced. If one tranquilizer sedates too much, another company sets its sights at a nonsedative tranquilizer—which, they tell us, is not a contradiction in terms.

It is a beautiful system, and when it reaches the end of the line it will have produced the ultimate tranquilizer. This will make us feel calm. It will remove fear of failure. It will throw up a selective blanket which will shield us from the winds of ill-fortune. It will bleach out any element of tension in the drive to accomplish. It will lend a rosy tint to the garish yellow of reality, as well as a pink coloration to what otherwise might be the blues. We will never crusade again for the right, because to be a crusader you must feel tension. We will accept evil with a shrug, for in a fully tranquilized culture, there is always calm. Everywhere there will be peace, for peace is but the plural of individual tranquility. No one will get worked up over nothing, or over something. We will all realize Sydney Smith's boon: "A man does not choose to be disturbed. He is more thankful to the one who confirms him in his errors and leaves him alone than to the man who instructs him at the expense of his tranquility."

Under the benign bed-spread of the ultimate tranquilizer, we will all come to rest. Gone will be the spur to invention, the drive to reform, the divine dissatisfaction that leads to progress. So we will rest, smiling at each

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other in the beatific calm of the ultimate tranquilizer, until some neighboring tribe, some rude and primitive people, move in on us. They will vanquish us with ease, because no one ever thought of giving the tranquilizer to our enemies as well as to our friends. And when the dust over our civilization stops being radio-active, a 30th century archeologist will find writ on the tombstone of our culture: "Here lies the tranquil man."

"You're Living on Nervous Energy"

It is hard to think of a pleasant diagnosis. No matter what the ailment, you are better off without it. However, the closest thing to a delightful diagnosis is "you're working too hard," or in the jargon of the less sophisticated, "you're living on nervous energy." The analogy of the storage battery is compelling. You have to rest to recharge the batteries.

And this is what makes the diagnosis delightful. Your symptoms now may be worn like a badge of honor. You are too conscientious. You work too hard. You have a right to sympathy from friends and coddling from a spouse. You are innocent of fault. Here at last is the great desideratum: sanctimony without criticism.

And the prescription? Also delightful. Atlantic City, Florida, the Bahamas, or Monaco, according to purse. Sleep late in the morning. Let others worry. Be waited on. No guilt. Indeed much righteousness.

Well, a doctor who says his name is J. Smith* has made a study of "overwork" and it was published on Bastille Day — July 14. Now Dr. J. Smith (a likely name!) found that half of the patients with the "overwork syndrome" were really suffering from hostility to a supervisor or disagreement with the boss generally. This, it seems, produced symptoms in day laborers and also in sub-senior executives. As a matter of fact, a boss-ridden worker was likely to live in a wife-centered home, so that he didn't get much relief from being a subordinate even when he was safely ensconced in what our humorous British brethren call his "castle." The tired feeling thus continued after the 5 o'clock whistle.

Of all the emotions, hostility is the most dangerous. It will, in this atom age, probably be the death of us. Hostility raises the blood pressure, pours acid into the stomach—and churns up the stomach walls too, and you know what *that* leads to—. Hostility produces wheezes in the chest, pours excess sugar into the blood stream and stimulates peristalsis in the lower gut. So overwork, salted with hostility, can really produce a syndrome. No matter what you do with this hostility, you can't win. If you let it express itself, you go pounding on table tops and get hypertension. If you swallow it down, you get ulcers.

Smith* also found that suggestion and emotional contagion played a role. One heart attack in an office will produce a dozen cases of precordial discomfort. Or, a worker has a grievance against the employer which he channels into demands for compensation and develops an occupational psychoneurosis. Then too, though Smith doesn't pay much attention to this group, there must be workers who have chronic disease—arthritis, asthma, ulcers, hypertension—and who do not get enough rest and relaxation and who thus suffer from overwork in its crudest form.

Also somewhat neglected in Smith's roster, is the role of ennui. Even a toothache seems less compelling when you are excited about your job. It is given to only a few of us (and we doctors are generally in this happy category) really to like our work. Thoreau† said that "the mass of men lead lives of quiet des-

*Smith, J.: Journal of the American Medical Association 161:1038 (July 14, 1956)

†Thoreau, H. D.: *Walden* (part 1).

peration." So boredom produces symptoms which may lead to the delightful diagnosis, *allergia operi*.

No, the diagnosis of "overwork" may be scientifically incorrect. But in a larger sense it is apt enough. Work that is anxiety-laden, work that is boring, work that generates hostility, is too much for most of us.

Take the afternoon off and get your batteries recharged.

One Born Every Minute

In a recent release,* Postmaster General Summerfield says that medical fraud is at the highest level in history. The quacks it seems, are doing their patriotic best to wipe out the postal deficit, for Mr. Summerfield's concern is with those nostrums that are announced and distributed through the mails.

Mr. David Stephens, the Post Office's chief inspector says that medical frauds are more lucrative than any other criminal activity. As some measure of the money to be made in this business, is the report that in a short period, 106 persons signed agreements to discontinue their questionable enterprises. These 106 were earning $225,000 a day—not per year or per month, but per day. That's an income of over $2000 a day to the individual entrepreneur.

What do you suppose is the most popular medical fraud? Cancer cures, relief for the common colds, sedatives for menstrual cramps? No. Number 1 in this hit parade is the quest for losing weight without diet. Cancer cures come second and arthritis cures third. After that, and in order, come nostrums for clearing up the skin, for growing hair on bald pates and for restoring sexual potency. The next item on the best-seller list is a bust developer. It would appear that no one ever went broke overestimating the force of human vanity.

To the conscientious physician, such a reading must be wearying—gives him tired blood, probably. But freedom of enterprise must include the freedom to be foolish. Actually our Post Office Department does very well in closing the mails to these frauds. The trouble is that new frauds seem to be born almost as rapidly as new customers. And you know how often *that* is.

Blue Shield is for Everybody

In creating and sponsoring Blue Shield, the doctor has helped launch a popular movement that will not be stopped until every potential member is enrolled in a pre-payment plan. Your Blue Shield plan has not only sold itself: it has sold the people of New Jersey on the *idea* of security against economic consequences of medical needs. In ten brief years, Blue Shield's nationwide enrollment skyrocketed from 2 to 37 million. Thus, by now, the job of providing voluntary care of this sort is about half done.

Blue Shield's purpose is to help the profession meet its responsibility to the entire community. Plans are now giving special attention to the segments of the population whose potentialities for profitable underwriting do not appeal widely to commercially operated insurance companies. The public is going to have more and more voluntary pre-payment for medical care. Can Blue Shield do the job satisfactorily and in good time? The answer lies with the doctor. American medicine has accomplished a modern miracle in Blue Shield. The part of the job still undone will require as much imagination, dedication and boldness as was needed to get Blue Shield off the ground a decade or two ago. To do this, Blue Shield needs your guidance.

*Published in the June 3, 1957 "Drug Trade News."

THOMAS K. RATHMELL, M.D.

Trenton

Cancer Advances*

CYTOLOGY OF PLEURAL EFFUSIONS AS AN AID IN CANCER DETECTION

This is the first of a series prepared by the Cancer Control Committee of The Medical Society of New Jersey. From time to time this committee will submit other papers on cancer control.

The first cytologic examination on human secretions was made on colostrum in 1838. Cytologic diagnosis has been firmly established through the work of Papanicolaou.[1] We have reviewed the cytologic pattern of pleural effusions studied in this laboratory during the past two years and found that the effusions not only vary in their cytologic pattern, but that this variation is of diagnostic import. Our technic includes centrifuging all specimens, making smears of the sediment and staining them according to Papanicolaou's methods. The sediment is collected on Japanese lens paper, subsequently processed as a histologic specimen and stained with routine hematoxylin and eosin. In some instances, the concentrated sediment may provide a cytologic picture which could not be appreciated adequately on the smear and on rare occasions, specimens so prepared may have diagnostic value equal to that of a biopsy.

The crux of cytologic studies of pleural effusions is to differentiate mesothelial cell proliferations of the pleura of a non-specific character (cardiac effusions) from actual proliferation of metastatic neoplastic cells. Typical mitoses and multinucleated cells may be seen in cardiac effusions. Atypical mitoses and bizarre multinucleated cells are a sign of pleural metastases.

The dictum that all hemorrhagic effusions are malignant cannot be substantiated. It is a matter rather of the degree of hemorrhage and its association with malignant cells. Malignant effusions tend to be morphologically bloody, yet the effusion of metastatic breast carcinoma has not shown hemorrhage as a prominent morphologic feature. Traumatic pleural effusions show hemorrhage.

The diagnosis of monocytic leukemia (either Schilling or Naegli type) from a pleural effusion is readily made by the pathologist. Smears of pleural effusions from such cases frequently resemble a bone marrow smear in cytologic detail, showing both monoblasts and monocytes.

Certain generalizations have become apparent as a result of this study. *First*: The cytologic study of pleural effusions (using the technics above described) reveals diagnostic information. *Second*: The oft-repeated statement that tuberculous effusions are usually lymphocytic cannot be substantiated. Our ob-

*This paper is derived from a presentation made by Dr. Rathmell in Hershey, March 21, 1957, at a session of The Pennsylvania Association of Clinical Pathologists.

Kodachrome illustrations of this material will be presented in the Spring 1958 issue of Merck Sharp & Dohme *Seminar Report*

1 Papanicolaou, G. N.: Atlas of Exfoliative Cytology, Harvard Univ. Press (1954).

servations show that tuberculous effusions may be of several general cell types. The only absolute criteria of tuberculous effusions are those from which the acid-fast bacillus may be isolated. Indeed, lymphocytic effusions in our series were shown to be derived from individuals with syphilis, lymphosarcoma, lymphatic leukemia and virus pneumonia.

Effusions associated with bronchogenic carcinoma were those in which neoplastic cells were readily identified. Acinar patterns of neoplastic cells were encountered only in pleural effusions in cases of bronchogenic carcinoma and carcinoma of the stomach. Carcinomas of the stomach appear to show distinctive signet-ring cells and cytoplasmic inclusions of mucin when metastasizing to the pleura. Perou and Littman[2] describe such findings in effusions from ovarian tumors. Carcinomas of the breast, metastasizing to the pleura, tended to present not only malignant cells, but the vacuolated cytoplasm of these cells, in some instances, appeared to be larger than that noted with gastric carcinomas. Atypical mitotic figures were numerous in pleural metastases of breast cancer. Ovarian carcinoma in pleural effusions presented neoplastic cells which clustered in a syncytial pattern, whereas those pleural fluids showing metastatic carcinoma from the uterine cervix showed neoplastic cells which were distinctly clumped.

It should be appreciated that cells of a pleural effusion are definitely subjected to cytologic alterations by the fluid of the effusion itself. The effusion of Hodgkin's disease, in our experience, showed eosinophiles and incompletely preserved cells with prominent eosinophilic nucleoli. These could be interpreted as classical Reed-Sternberg cells, the cytoplasm of which has been subjected to dissolution by the pleural fluid, the chemical agents introduced into the pleura as a therapeutic measure, or by the technic of processing the material for cytologic study. Other workers[3] have had similar impressions of Reed-Sternberg cells in pleural effusions. Information of diagnostic significance *can* be obtained by the alert pathologist who will devote a modicum of time to the proper study of pleural effusions.

The identification of an effusion as "tuberculous" requires that the bacillus of tuberculosis be isolated from the fluid. The cytologic picture of the pleural fluid from different diseases appears to be morphologically distinguishable. Cytologic studies of pleural effusions give diagnostic information which is helpful to the clinician. Pleural effusions containing malignant cells are readily identified by cytologic methods. Clinicians are urged to use cytologic studies of pleural effusions as an aid in cancer detection.

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3. Dawe, Clyde J., Woolner, Lewis B., Parkhill, Edith M., McDonald, John R.: Cytologic Studies of Sputum, Secretions and Serous Fluids in Malignant Lymphoma. Am. J. Clin. Path. 25:480 (1955).

446 Bellevue Avenue

Radio-active Iodine and the Thyroid*

Parry, in 1786, first described hyperthyroidism as a "disease of the heart." The adverse effect of hyperthyroidism on the heart is now well known. Since 1947, Dr. Blumgart's group has been studying the effect upon the cardiac status of depression of thyroid function in euthyroid individuals.

Radio-active iodine (I-131) has been used in depressing thyroid function in individuals with angina pectoris and with congestive failure. Only patients refractory to other medical therapy have been so treated. The results of the Harvard group and of others, indicate that a large proportion of both classes of patient can be improved by irradiation of the thyroid with I-131. Seventy-eight per cent of the patients with intractable angina and 68 per cent of those with congestive failure showed improvement following I-131 therapy. No toxic effects of radiation have been observed. The parathyroid glands are unaffected.

*Abstracted by Dr. Paul DeR. Kolisch of Phillipsburg, N. J. from testimony, June 1956, before the Congressional Committee on atomic energy. This testimony was given by Dr. H. L. Blumgart of Harvard.

Lee Gillette, M.D.

New York, N. Y.

Repair of Common Duct Injuries*

For common duct injuries, Dr. Gillette recommends choledocho- or hepatico-duodenostomy as a simple, rapid and effective means of restoring the biliary flow. The technic is described. Other methods are also reviewed.

Patients who have suffered an injury of the common duct offer some of the most challenging problems in surgery. Although many respond to surgical repair, approximately twenty-five per cent of them [1] develop repeated stenosis which defies every attempt at reconstruction.[2] The first consideration of any surgeon who works in the right upper quadrant is to use all the means at his command to avoid such an injury.

Almost every entero-biliary anastomosis, anatomically feasible, has been tried, and if properly performed has, in some measure, been successful. Also, every conceivable material has been used in the attempt to reconstruct the common bile duct but this approach has been far less rewarding.

The three most commonly used methods of repairing duct injuries give similar results. The proportion of good results in each method used varies from 60 to 75 per cent in numerous reported series.

End-to-end reconstruction of the common duct over a rubber tube was first used by Doyen [3] in 1892. It has recently been advocated by Lahey [4] and Cattell [5] and employed by them in a fair proportion of their cases (approximately 50 per cent). This method was used in four of our cases and is preferable in cases of very recent injury.

Another widely used method is the Roux-en-y choledocho-jejunostomy.[6] This is the technic advocated and used with excellent results by Cole and his co-workers.[7] It was apparently first employed by Mon Profit [8] in 1908. However, in my experience, it has been unnecessary to by-pass the intestinal contents in this fashion.

The third method, that of anastomosing the common or common hepatic duct to the duodenum, was first tried by Sprengel [9] in 1891. It is the method of choice in the Mayo Clinic experience, as reported by Walters,[10] and was used to repair ten of the cases in our series. This is the method that I favor. I use it wherever there is real concern about the freedom of passage in the lower common duct.

*From the Division of Surgery, The Roosevelt Hospital. This paper was presented before The Medical Society of New Jersey, General Session on Surgery, Atlantic City, New Jersey, April 30, 1957.

1. Donaldson, G. A., Allen, A. W. and Bartlett, M. K.: New England J. of Medicine, 254:50, Jan. (1956)

2. Glenn, F.: American Journal of Surgery, 91:534 (1956)

3. Doyen, E.: Archives Provinciales de Chirurgeuie, 1:149 (1892)

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7. Cole, W. H.: Post Grad. Med., 19:464 (1956)

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10. Walters, W. and Kelly, A. H.: A.M.A. Arch. of Surg., 66:417 (1953)

The procedure of anastomosing the peripheral hepatic ducts, in cases where the porta hepatis no longer offers a proximal stump of proper length or quality for an anastomosis, was first suggested by Langenbuch[11] in 1897. It has been extended and advocated by Longmire and Sanford.[12]

Two maneuvers that have proved particularly useful in splinting the entero-biliary shunt deserve mention. One is the implantation of a mushroom catheter through a choledochoduodenostomy, which can be removed later by a simple duodenostomy or without surgery, if brought outside the abdomen through a Witzel gastrostomy (several lateral openings being made in the wall of the catheter to allow the bile to drain into the duodenum).

The other (the so-called Grindlay) maneuver, is a similar procedure of bringing a tube through the anastomosis and out through the substance of the liver.

Both have the advantage of rapid accomplishment and good splinting of the anastomosis.

Lahey[4] includes 24 cases of stenosis of the sphincter of Oddi in his review of bile duct strictures. I have encountered 35 such cases in the course of this study. Twenty-three were treated by external sphincterotomy[13] and twelve were treated by trans-duodenal sphincterotomy with good results and no mortality. Also found were two spontaneous strictures of the supra pancreatic area which were treated by dilatation and T-tube splinting with good results. No cases of benign intrahepatic stricture were encountered although we were carefully searching for them[14] (Figure 1).

TECHNIC

THE abdomen is opened with a subcostal incision parallel to the liver edge. Any adhesions between the liver and the abdominal wall are carefully preserved. Traction clamps (Kocher) are applied to the upper margin of the fascia, and the liver is rotated slightly upward, and brought forward into the wound. (On several occasions, I have seen these helpful adhesions tediously and bloodily severed without any result, except that of dropping the liver further into the operative field.)

A moist gauze pad is placed on the colon and duodenum, and with a good light and traction, a careful sharp dissection is carried down to the level of the common duct (Figure 2). The

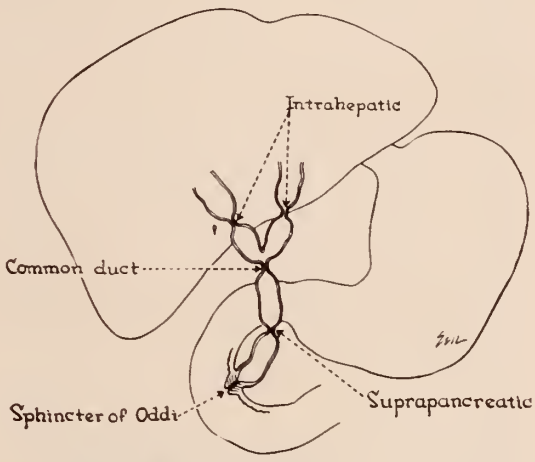


Figure 1. Showing the main areas in which bile duct strictures are encountered. The area marked common duct is the level at which most traumatic strictures occur.

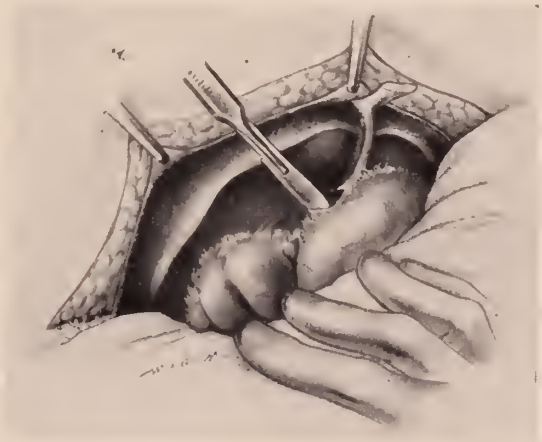


Figure 2. Technic of secondary biliary dissections. Note: (1) Paracostal incision; (2) traction on upper and lower edges of wound; (3) sharp dissection.

11. Langenbuch, J. A.: *Chir. der Leber und Gallenblase*, Stuttgart, Enke, 2:357 (1897)
12. Longmire, W. P., Jr., and Sanford, M. D.: Surgery, 24:264 (1948)
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14. Carter, R. F. and Gillette, L.: Journal of the A.M.A., 145:375 (1951)

dilated duct stump is aspirated and 35 per cent idiopyracet (USP)† is injected for a cholangiogram. This gives the vital information, as to whether the injury is below the junction of the hepatic ducts and tells whether there are stones above the stricture. The duodenum is found at this level and does not have to be mobilized or brought up to the strictured duct. In the occasional case where the stump does not present itself easily, a jejunal loop may be used.

The common hepatic duct is opened, and then the duodenum is opened through a small stab wound. As the opening tends to enlarge while it is being worked on, it is best to start with a small opening.

Interrupted silk sutures are taken between the adventitial layers of the common duct and the seromuscular layers of the duodenum. A row of interrupted 2-0 chromic catgut sutures is made to complete the posterior part of the anastomosis.

Placement of a T-tube in the duct above, with the lower limb running through the anastomosis, would be preferable; but in actual practice, the stump is usually so short that the long arm of the T-tube is brought out through the anastomosis of the common hepatic duct and the duodenum (Figure 3). Hence, the anterior row consists of only two or three interrupted sutures of catgut; and to these, a second row, consisting only of a few silk sutures is added. The anastomosis is thus simple and can be rapidly accomplished, which is a great advantage in operating on patients who are not in the best of condition.

After two weeks, the T-tube is clamped, and it is then left in place for a minimum of three months. My preference is to leave it in for six to nine months while the scar at the anastomosis contracts during its maturation. After surgery, occasional courses of bile salts and irrigation of the tubes with sterile saline are used, in an attempt to prevent incrustation of the tube with the bile salts. The tube which lies half in the biliary tract and half in the intestinal tract must have a clamp close to the skin, in order to prevent its being milked into the intestines. The milking may occur within a few hours if the clamp is removed, even temporarily, for the relief of skin irritation.

It is important for the patient to understand that he must chew all food very carefully to prevent blocking of the anastomosis by small particles of meat or vegetables. Patients may carry on their normal occupation and recreational activities with the tube in place.

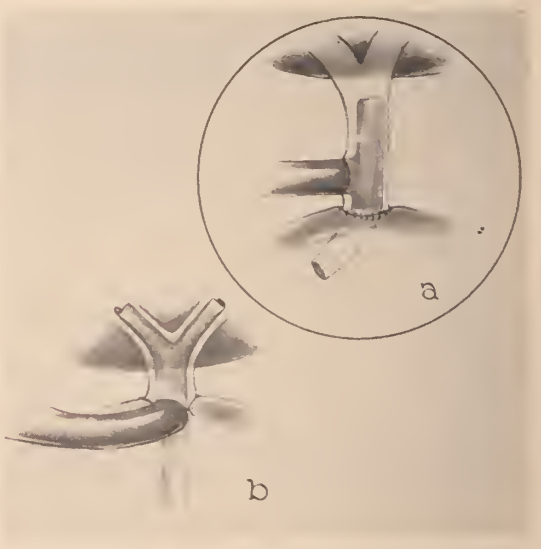


Figure 3. (A) The ideal situation in choledochoduodenostomy with the lower limb passing through the anastomosis and the vertical limb coming out of the common duct. (B) The usual situation with the duct stump so short the upper limb has to be split and inserted in each hepatic duct and the vertical limb has to be brought out through the choledochol-duodenal anastomosis.

At Roosevelt Hospital, we had one patient, a lawyer, who felt very well postoperatively and refused to give up his tube, which he wore for two and-a-half-years. He consented to part with it only when he became jaundiced, due to blockage of the tube with bile salts. This, amusingly, enough, resulted in loss of some prestige in his golf club shower room, where he had been known as "the man with the hose in his side"!

Three of the most interesting cases of common duct injury and repair are herewith presented.

† Under the Winthrop-Stearns tradename of Diodrast®.

CASE ONE

A 56-year old woman was admitted in April, 1953, after 38 years of jaundice from a common duct injury resulting from a cholecystostomy. In 1915, she had been operated upon after suffering from jaundice for three weeks. Apparently, she sustained a common duct injury during the cholecystostomy that was done at that time. She continued to be jaundiced and had an intermittent biliary fistula. That same year, she was treated again by surgery, the nature of which is unknown.

She was intermittently jaundiced until 1932, when she had an unsuccessful exploration. She remained jaundiced, and when examined in April, 1953, was emaciated and icteric. Her liver was four-finger breadths below the costal margin, and the liver chemistries pointed to obstruction. Shortly thereafter, the abdomen was explored. The gall bladder contained only white bile and was removed. The proximal hepatic stump, the size of a broom handle, was dissected free and a cholangiogram was performed (Figure 4). This revealed a markedly dilated hepatic tree and a one cm. in diameter calculus. A choledocho-duodenostomy was performed over a size 30 French T-tube.

The patient made an excellent recovery, gained 50 pounds, and has been free of symptoms ever since (Figure 5).

CASE TWO

A 37-year old man was admitted to the hospital in April, 1953, for repair of a biliary and intestinal fistula.

On the first of that month, he had had a cholecystectomy and choledochostomy. Postoperative cholangiogram had shown retained common duct stones. A second operation had been done to drain a subhepatic abscess. Five days thereafter, a small intestinal fistula had developed in the wound.

On admission, it was found that the patient had a large defect of the upper right quadrant, with a pool of fecal material and bile draining from it.

At surgery, the area was suctioned clear and "prepped;" through a paracostal incision the adhesions were dissected free, and three feet of ileum containing the fistulous opening and other adherent and inflamed loops were resected. A side-to-side anastomosis, using three layers of sutures,



Figure 4. Case 1. Operative cholangiogram showing a strictured common hepatic duct injured 38 years prior to this operation. Patient jaundiced during all this time.



Figure 5. Case. 1. G. I. series with excellent visualization of the biliary tree 4 years postoperative. The bile ducts always visualize well when patient asymptomatic.

was performed. The common duct was opened and a large number of black pigment stones were removed. There was a great deal of black sludge. This was irrigated and removed with scoops and Blake forceps. An operative cholangiogram revealed a dilated biliary tree but no further stones. A two-layer cholodocho-duodenostomy was performed over a size 26 French T-tube.

Three cigarette drains were inserted and the abdomen was closed with No. 3 through-and-through silk sutures. There were large areas of defect in the fascia which could not be closed and this resulted in an unavoidable ventral hernia.

The patient made a good recovery, gained 63 pounds, and has had no gastro-intestinal symptoms since that time. The T-tube was removed six months after the operation.

CASE THREE

A 56-year old man was admitted to The Roosevelt Hospital on June 21, 1954. He represents a case of common duct injury during gastrectomy.

In January, 1952, he had a subtotal gastrectomy for obstructing duodenal ulcer. Four days later, he was operated upon again because of jaundice. A cholecystostomy and drainage of a subhepatic collection was done. One month later, on re-exploration for persistent obstruction, he was found to have a thickened lower common duct, with obstruction and induration of the head of the pancreas. A dual by-pass, a cholecysto-duodenostomy and a pancreatico-duodenostomy were created. He did well for one year and then had an episode of pain, fever and jaundice.

Upon his first admission to Roosevelt Hospital in 1954, he was mildly jaundiced and his liver chemistries were typical of obstruction. He had three admissions altogether for these symptoms and during the third, he was operated upon by the resident surgeon. On April 22, a cholecystectomy was done and a choledocho-duodenostomy performed with an indwelling rubber tube through the anastomosis. He developed a biliary fistula and jaundice postoperatively.

On July 28, 1955 operative cholangiogram revealed a stricture, low on the common duct (the injury is much lower in gastrectomy than in biliary tract surgery), with complete obstruction. A choledocho-duodenostomy was performed over a large T-tube which was left in situ for nine months.

The patient has gained weight and has been asymptomatic since the operation.

COMMENT

FIFTY-ONE cases of benign fibrous stenosis of the common duct are covered in this report. Fourteen cases of repair of surgically injured common ducts are presented as well as two cases of stricture of the supra pancreatic area, and thirty-five cases of obstruction at the sphincter of Oddi.

Most observers of the problem presented by surgically injured common ducts now agree that stenosis of the anastomosis (and not reflux of intestinal content and bacteria) is responsible for the failures and for symptoms that follow the repair of some of these injuries.

This has been confirmed time and again in many patients on whom a choledocho-duodenostomy was performed. Gastro-intestinal barium x-rays have invariably revealed filling of the ducts in patients without symptoms and no filling in the case of those with symptoms of chills, fever and jaundice (Figure 6).

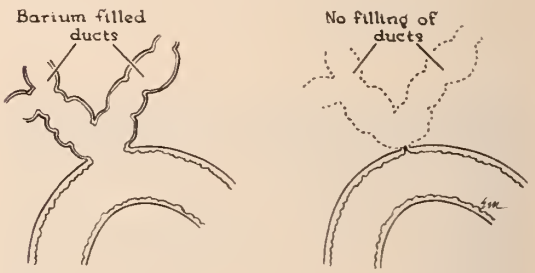


Figure 6. Diagrammatic representation of G. I. series post-choledocho-duodenostomy. In the asymptomatic patient as on the left the ducts fill well with barium. In the patient with symptoms the ducts do not fill with barium. Therefore it is stenosis of the anastomosis not reflux that produces symptoms. (Figure on the right)

These facts have led me to conclude that the Roux-Y procedure or other methods to divert the intestinal content from the anastomosis, are unnecessary. I advocate an operative cholangiogram to outline the ducts, to reveal any stones that may be present, and to show the level of the junction of the right and left hepatic ducts.

In these sick patients, I prefer the speed and simplicity of a choledocho-duodenostomy. Where possible, I prefer to insert the T-tube above the anastomosis, with the lower limb running through it. However, the hepatic duct remnant is usually so short that the vertical arm must be brought through the anastomosis. In many cases, the upper arm has to be split

in two, with one-half going up each hepatic duct. Bringing the vertical arm out through the anastomosis does have the advantage of substituting for the anterior part of the anastomosis, which consists of two or three sutures on either side of the T-tube.

In our fourteen patients, the injury to the common duct occurred during biliary tract procedures in thirteen, and in one case, during a gastrectomy.

Four of the patients had end-to-end repair, and ten had a choledocho-duodenostomy. I prefer the latter procedure for severe cases, as it is often a fruitless, difficult and time-consuming task to hunt for the lower end of the common duct.

There were no operative deaths in the entire group of 51 patients. The results in the 14 common duct injury cases were good in nine, fair in four and poor in one.

CONCLUSIONS

1. The repair of common duct injuries is a difficult problem. Even under the best management, 25 per cent of the patients treated are doomed to permanent disability or death.

2. Malfunction of a cholenteric anastomosis is due to stenosis and not to reflux. Patients with symptoms do not reveal filling of the biliary tract in a gastro-intestinal series—those without symptoms have excellent barium visualization of the ducts.

3. Based on the experience with fourteen patients covered in this report, choledocho- or hepatico-duodenostomy is advocated as a simple, rapid and efficient means of restoring the biliary flow. This conclusion has been confirmed by published reports of other investigations.

850 Park Avenue

The author acknowledges with thanks the courtesy of Dr. Howard A. Patterson for his review of this paper, the editorial assistance rendered by Mrs. Rose M. Schweitzer, Editor for Clinical Research, Roosevelt Hospital and a grant from the Carter Foundation, N. Y.

X-ray Study of Timed-Disintegration Capsules

An *in vivo* roentgenographic study* of timed-disintegration capsules showed that (contrary to the common impression) the contents are scattered widely throughout the length of the gastro-intestinal tract before the individual particles disperse or dissolve. The popular belief that the mass of the capsule contents remains in a single blob, based on an artist's conception, is shown to be erroneous.

In the present study four different kinds of timed-disintegration capsules, containing radiopaque barium sulfate (substituted for the usual active medication) were used. The first type was for immediate disintegration, the second for timed disintegration in about two hours, the third in about four hours, and the fourth in about six hours. Roentgenograms were taken immediately after ingestion and repeated in two, four, six, eight and ten hours.

The roentgenographic technic demonstrated a longer disintegration time than the modified U.S.P. method. The disintegration time was two to four hours as compared with two hours by U.S.P. technic, four to six hours as compared with four hours, and six to ten hours as compared with six hours. It is believed that the roentgenographic technic offers a more accurate picture because it is an *in vivo* method. The great convenience of the timed-disintegration capsule makes it an ideal method for the administration of drugs usually given in three divided doses.

*Feinblatt, T. M. and Ferguson, E. A., Jr.: Timed-disintegration Capsules, An *in vivo* Roentgenographic Study, New England J. Med. 254:940 (May 17) 1956

Abraham I. Friedman, M.D.

Hackensack

Vincent H. Gillson, M.D.

Paramus

Serum Ammonium Levels in Liver Disease*

In liver disease, serum ammonium levels were found more significant in arterial than in venous blood. Potassium sodium glutamate seems to be a useful adjunct in the treatment of hepatic coma.

There are three important sources of ammonia in the human organism: the intestinal tract, the kidney and the metabolic processes of deamination. By far the largest amount of ammonia is derived from the intestinal tract. Here, ammonia is produced by the enzymatic action of colon bacteria on ingested protein in the diet. Aminoacid oxidase and urease degrade protein to aminoacid and urea and finally, ammonium. Ammonium enters the portal system and is synthesized by the liver to urea. The latter is excreted by the kidneys or again split to carbon dioxide and ammonium after diffusion into the intestinal tract. The synthesis of urea by the liver is the chief mechanism for the elimination of ammonium in man; only about 10 per cent is excreted by the kidney[1] as ammonium. High blood levels of ammonium in liver disease occur as a result of (a) hepatic failure to synthesize urea and (b) shunting of the portal blood from the liver to the systemic circulation. It is well known that not only extra-hepatic but intra-hepatic shunts develop between the portal and systemic circulation. Spontaneous shunting as observed in portal cirrhosis or surgical shunting as occurs following porto-caval anastomosis appear to be a necessary condition for the psychiatric manifestations, *i.e.*, ammonium intoxication and coma, of severe liver disease.

Impending hepatic coma and hepatic coma are usually associated with elevated serum ammonium levels. Clinical deterioration of the patient is associated with progressively elevated serum ammonium levels and *vice versa*. In this study the critical level of ammonium at which hepatic coma developed was 3 mcg/ml. although an occasional patient became comatose at a lower level.

The correlation between coma and elevated ammonium is not absolute. Infrequently, there are patients in coma who present normal levels of ammonium and rarely, a cirrhotic will possess higher levels than 3 mcg/ml. without presenting psychiatric manifestations. However, determination of arterial ammonium levels reveals a much closer correlation than venous levels. We now do arterial determinations exclusively.

Why does ammonium intoxication lead to hepatic coma? The physiologic mechanism is

*Based on a scientific exhibit presented at the Annual Meeting of The Medical Society of New Jersey at Atlantic City, May, 1957. This work is from the Departments of Medicine and Pathology, Bergen Pines County Hospital, Paramus, N. J.

1. McDermott, W. V., Jr., Adams, R. D., Riddell, A. G.: Annals of Surgery, 104:539 (1954).

CHART 1A: WITHOUT PSYCHIATRIC MANIFESTATIONS

Case	Hepatomegaly	Ascites	Serum Bilirubin	Serum Protein	Serum Ammonium[1]	Pathology
A	+	+	2.3/1.3	2.2/2.6	2.0	Diffuse portal cirrhosis, advanced
B	+[2]	—	3.2/1.5	2.9/2.6	1.7	Diffuse portal cirrhosis, advanced
C	+	—	5.9/2.0	1.9/5.4	1.2	Multiple myeloma — coma
D	+	—	1.2/0.4	3.8/2.8	1.6	Mod. advanced portal cirrhosis
E	+	—	5.9/2.2	2.7/4.7	2.8	Advanced portal cirrhosis
F	+	+	8.4/2.5	2.9/3.2	1.1/1[3]	Advanced portal cirrhosis

CHART 1B: PATIENTS DISORIENTED OR IN COMA

Case	Hepatomegaly	Ascites	Serum Bilirubin	Serum Protein	Serum Ammonium[1]	Pathology	Course
G	+	+	15.9/6.5	3.2/3.1	13.6	Adv. diffuse port. cirrhosis	D
H	+	+	8.4/4.6	3.2/2.2	6.7	Adv. diffuse portal cirrh.	D
I	+	+	3.5/2.9	4.9/4.2	5.9/2[3]	Adv. portal cirrhosis (panc.)	D
J	+	+	12/5.7	3.4/3.1	14	Fatty change. Adv. port. cirr.	D
K	+	+	23/10.	———	2/3.5	Metastatic carcinoma	D
L	+	+	6.5/2.1	2.5/3.9	1.9/1.1[4]	Diffuse portal cirrhosis	I
M	+	+	6.8/3.2	2.4/4.2	3.5	Severe portal cirrhosis	I
N	+	+	12/8.4	1.6/2.4	4.	Severe portal cirrhosis	I

CHART 2. PROGRESSIVE SERUM AMMONIUM LEVELS REFLECTING CLINICAL COURSE

Case	Diagnosis	Serum Bilirubin	Serum Protein	Serum Ammonium [1]	Course
P	Advanced p.c. Impending coma	8/3.7	2.5/5.3	5.2—7.2. Coma. 8.4/9.8 [3]	D
Q	Adv. p.c. Alcoholism. D.T.s	1.9/1	2.7/1.7	5.3 Confused. 3.0-2.0	I
R	Schizophrenia & hepatitis	1.9/0.7	2.9/4.5	6.2 Confused. 3.7-2.6	I
S	Severe portal cirrhosis	2/1.2	2.7/2.8	2.6. (paral) 5.1 (anuria). 6.9 [6]	D
T	Severe portal cirrhosis	1.7/1.2	2.9/3.2	2.8 Confused. 1.3/1.2[3]	I
W	Severe portal cirrhosis	24/9.5	2.9/2.9	6.6/3.5-3/2.2-2.3	I
X	Severe portal cirrhosis	6.8/3.2	2.4/4.2	3.5 Disoriented. 2.5-2.	I
Y	Postnecrotic portal cirrhosis	2.1/0.7	4.2/1.4	6 (semiconscious) 1.3-5.9 [7]-2.2	I

1 Micrograms per milliliter
2 Splenomegaly
3 Arterial-venous
4 Following glutamate
5 Transfusion
6 Coma
7 Confused

intimately related to the Krebs cycle.[2] A simplified schematic outline reveals that following phosphorylation glucose yields oxalacetic acid which in turn is oxidized to alphaketoglutaric acid. The latter combines with ammonium to yield glutamic acid and glutamic acid plus ammonium produces glutamine. There are two possible methods by which the elevated ammonium is presumed to affect the cerebral consciousness. One, the high concentration of ammonium inhibits the formation of alphaketogiutaric acid. This in turn inhibits glucose metabolism and the most important element of cerebral nutrition is depleted and brain function disturbed. Two, the increase in ammonium depletes alphaketoglutaric acid by forming glutamic acid and removes one of the essential intermediate substances participating in the cycle of oxidative aerobic glucolysis.[3] Whichever the actual mechanism, psychiatric disturbances become manifest due to failure of cerebral ammonium uptake.

The rationale for the administration of glutamic acid in hepatic coma is the removal of the elevated blood ammonium to form glutamine. The latter substance is transported to the kidney and ammonium excreted. Although this method of excretion is of secondary importance in the normal organism it serves as a bridge during periods of crisis.

The treatment of hepatic coma has taken an important step forward since the work on ammonium metabolism (Table 1). Regardless of the underlying pathology, those methods of therapy previously employed are still basic and include the liberal use of enemas and laxatives when necessary, to remove protein materials and blood from the lower intestinal tract. Oral antibiotics are essential to sterilize the colon bacterial flora whose enzymes are responsible for the liberation of ammonium. We prefer Neomycin®. Parenteral antibiotics are employed in the comatose patient. The control of hemorrhage by esophageal tamponade is important to prevent endo-

TABLE 1. TREATMENT OF IMPENDING HEPATIC COMA

1. Inhibit the formation of ammonium by bacterial enzymes in the lower bowel with the liberal use of enemas and the administration of oral antibiotics (Neomycin®).
2. Control of hemorrhage.
   (a) Control bleeding with esophageal tamponade to prevent absorption of endogenous sources of ammonium and reduction of hepatic blood flow. Surgery (trans-thoracic ligation).
   (b) Remove blood if present by laxatives and enemas.
3. Infusion of glutamic acid as potassium and mono-sodium glutamate salts following determination of arterial levels of serum ammonium if possible.
4. Avoid exogenous sources of ammonium: protein in diet, protein hydrolysate, methionine, and ammonium chloride.
5. High carbohydrate intake; free or low protein diet.
6. Avoid medications which depress cerebral metabolism and reduce hepatic blood flow (narcotics, sedatives and Diamox®). Use promazine and other tranquilizers for sedation.
7. Restrict transfusions to a minimum.

TREATMENT OF HEPATIC COMA

1. In addition to above and where oral medication is impossible administer parenteral antibiotics.
2. Infusions of glucose.
3. Steroids (?)

2. (a) Krebs, H. A.: The Enzymes: Chemistry and Mechanism: page 867, *Academic Press*, 1952, New York.
   (b) Soskin, S. and Levine, R.: Carbohydrate Metabolism, page 18; *University of Chicago Press*, Chicago, 1952.
3. Bessman, S.: Annals of Internal Medicine, 44:1036 (1956).

genous sources of protein and consequent ammoniacal absorption from the lower bowel as well as the more imminent threat of shock. The control of hemorrhage will also prevent reduction in hepatic blood flow and function. Occasionally, emergency surgery by means of transthoracic ligation may be necessary. Simultaneously with the above is the administration of glutamic acid as the potassium and mono-sodium glutamate.† Although oral therapy has been used sometimes with success, the intravenous infusion is a much more satisfactory method of administration. The introduction of potassium salts into the mixture has lessened the hazards of alkalosis. Glutamic acid should be administered as long as cerebral manifestations are evident and as long as coma persists. Although correlation with ammonium levels is useful, once the ammonium level has been determined, the administration of glutamic acid should be correlated with the clinical status of the patient, not with the ammonium level. A dose of 100 cubic centimeters of the potassium sodium mixture in glucose should be administered three times a day or more frequently if necessary. Protein in the diet should be avoided particularly in the early stages of impending coma. Infusions of intravenous protein, hydrolysate, oral methionine and ammonium chloride should be avoided. Narcotics and sedatives should not be given. The tranquilizers, such as promazine appear much safer for the disoriented patient. Acetazoleamide in the treatment of ascites in the severe cirrhotic should be avoided. A low or free protein diet is most useful for the patient in impending coma. Glucose infusions with the addition of parenteral vitamins are adequate in coma. Although some patients are precipitated into coma by hemorrhage, blood replacement should be kept to a minimum. The effect of high ammonium concentration in the transfused blood may be worse for the patient than the benefits to be derived from the increase in blood volume and the improvement in hepatic blood flow.

Although we have had rarely an apparent striking benefit from the use of intravenous ACTH these effects have been inconsistent and their use in coma routinely is not recommended at present. In an earlier study[4] only one out of twenty-four patients in coma recovered. Under the present regimen with the administration of glutamic acid two of three patients in coma have recovered. Indeed, three patients in impending coma have been restored to a satisfactory clinical status. All were cases of portal cirrhosis. The results were particularly gratifying because two of the patients appeared to develop coma as a result of an acute exacerbation of their cirrhosis.

PATHOLOGY

THE basic etiology of hepatic coma in 10 of our 12 cases was an advanced Laennec portal cirrhosis secondary to chronic ethanolism; in one patient, the cause was metastatic carcinoma primary in the stomach. One was due to post-necrotic cirrhosis. The diagnosis was established either by needle biopsy, postmortem examination, or both. A variety of tissue staining was employed to demonstrate the obvious and the more subtle morphologic changes.

The portal cirrhotic specimen showed a diffuse intrahepatic fibrosis of variable degree resulting in a universal partitioning and distortion of the liver lobules. In many areas, the remaining islands of parenchymal cells showed disorganized efforts at compensatory regeneration and pseudolobule formation. The tongues of scar tissue extending outward from the portal spaces were lightly infiltrated with mononuclear cells. Hyperplastic small bile ducts were frequently found within them. It was principally in these locations that the engorged vascular channels had developed many fistulae between the portal venous and hepatic arterial circulations. In many instances the liver cells contained large globules of fat which further compromised the functions of the organ. Where cellular necrosis had supervened the extruded fat could be found between the cells and within the fibrous septa.

†We are indebted to the Abbott Laboratories and Dr. A. E. Osterberg, Director of Research, for liberal supplies of this material.

4. Friedman, A. I.: American Journal of Gastroenterology, 27:23 (1957).

In necropsied cases, the liver was generally smaller than its expected size and weight. An occasional case was encountered, however, in which the liver showed no shrinkage, and indeed, was larger than expected due to severe fatty metamorphosis. Microscopy here revealed the coexistence of a dense parenchymal fibrosis with heavy accumulations of intracellular lipid. The liver in other cases presented a dull green color from excessive bile stasis of intra-hepatic origin.

The extent of the hepatic parenchymal damage and fibrosis in a large measure coincided directly with the chemico-clinical manifestations in each of these cases. It is important to recognize, however, that not all cases of cirrhosis are associated with significant disturbances in ammonium metabolism but when this disturbance exists the hepatic damage is severe.

CONCLUSIONS

1. Progressively increasing levels of serum arterial ammonium in patients with liver disease were associated with deterioration in the clinical course. Improvement in the level of serum ammonium was associated with recovery.

2. The correlation between serum arterial ammonium levels and coma is much more precise than with serum venous levels. Usually, a level of 3 mcg/ml. was associated with impending or actual coma.

3. Potassium sodium glutamate gives promise of being a valuable adjunct in the treatment of hepatic coma.

4. There is no pathologic pattern characteristic of hepatic coma. Elevated serum ammonium levels are usually associated with severe hepatic damage.

405 State Street

Smoking and Hypertension

A marked relationship between hyper-reactivity to smoking and familial hypertension was discovered in a study of medical students conducted by Thomas, Bateman and Lindberg of Johns Hopkins School of Medicine.*

"Subjects with parental hypertension, whose control cardiac output and cardiac index were large to begin with, showed more than twice as much increase in mean cardiac output after smoking one cigarette as did subjects with negative parental history."

Of the 113 persons studied, 10 were women; 82 were smokers and 31 nonsmokers. Outstanding findings after smoking one cigarette were listed as follows:

1. Systolic pressure rose more in women than in men.
2. Pulse pressure narrowed more in men than in women.
3. There were no significant differences found between smokers and nonsmokers.
4. Subjects with parental hypertension showed a greater increase in cardiac output and cardiac index than did subjects with negative parents.
5. Subjects with parental coronary artery disease showed a much smaller increase in cardiac output and cardiac index than did subjects with negative parents.

"Studies indicating a relationship between hyper-reactivity to smoking and to the cold presser test on the one hand, and those showing that hypertensive patients react more strongly to smoking than do normotensive subjects, on the other, are in harmony with the hypothesis that hyper-reactivity appears more frequently in individuals who are the offspring of hypertensive parents and may be a precursor of hypertension in a given individual," the authors declared.

*Annals of Internal Medicine 44:874 (May) 1956

E. D. Pellegrino, M.D.

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Flemington

Clinical Toxicity of Methyprylon (Noludar®)

CASE REPORT AND REVIEW OF TWENTY-THREE CASES*

Methyprylon is one of the safest of hypnotics but, as here shown, it can be toxic in overdosage.

Recently a number of non-barbiturate central nervous system depressants have become available for general use as sedatives and hypnotics. The effects of these compounds and of barbituric acid derivatives, both in experimental animals and in man, are quite similar. With widening use of these newer agents, the opportunity of observing and evaluating toxic effects of overdosage presents itself. Clinical information on the margin of safety and the best method of management of poisoning from excessive doses of these drugs is of increasing importance.

Methyprylon is among the more frequently prescribed depressants of the non-barbituric type. Except for Reidt's report of one fatal case,[1] the literature is devoid of comments regarding clinical manifestations and management of overdosage of methyprylon

We had occasion to study a patient who, in a suicide attempt, took an overdose of methyprylon. This report is concerned with the observations made, the therapeutic measures tried and the patient's response. Information on other cases of intoxication with this drug will also be reviewed.

A 45-year old man was admitted to the hospital in deep coma. According to information obtained from the patient, following his recovery, and from his family, he had been despondent about business reverses and had been deeply concerned about the possibility of organic heart disease. Examination by the family physician, several days before admission to the hospital, failed to reveal any abnormalities. An electrocardiogram, recorded at that time and later reviewed by us, was entirely within normal limits.

On the day of admission the patient had ingested seventeen 200 milligram tablets of methyprylon, or 3.4 Gram, in a suicide attempt. He later said that he took the medication at about 1:00 p.m. He was found unconscious and unresponsive at approximately 3:00 p.m.

His past medical history was not significant, except that he was known to have had a lowered basal metabolic rate. This was recorded as minus 25 per cent, at the last determination several years ago.

Findings on Admission: Patient responded to the most painful stimuli by groaning. There was slight cyanosis of the lips and nail beds. His temperature was 101.5. Pulse rate was 104 and the blood pressure 130/80. Respirations were shallow at a rate of 18 per minute. The skin was warm. A moderate amount of sticky secretion was present in the pharynx. General physical examination did not reveal any abnormalities, except for the presence of a few crackling rales at both lung bases.

The pupils were normal. Gross abnormalities of the extra-ocular muscles were not apparent. Reflexes were equal and active in the upper extremities and somewhat hyperactive in the lower extremities. Abdominal reflexes were equal and active in all quadrants. Bilateral ankle clonus was present.

Urinary findings were normal except for a trace of a reducing substance and one plus acetone. The hemoglobin was 14.5 Grams. The leukocyte count was 17,000 with 78 per cent segmented and 4 per

*From the Hunterdon Medical Center, Flemington, N. J.

cent non-segmented neutrophiles, 10 per cent lymphocytes and 8 per cent monocytes. The hematocrit was 46 per cent and the blood sugar 218. Barbiturates were not demonstrable in urine and gastric washings.

Therapeutic Measures and Patient's Response: A gastric lavage was done on admission. A pharyngeal airway was put in place. The tracheal secretions were aspirated. Oxygen was administered by nasal catheter. Penicillin and Distrycin® were given because of the elevated temperature and the presence of rales at the lung bases. One thousand milliliters of a solution containing 5 per cent glucose in water, followed by 1,000 milliliters of 5 per cent glucose in normal saline solution were administered by intravenous drip within 12 hours. During the first 12 hours, the systolic blood pressure ranged from 120 to 130 and the diastolic from 68 to 80. The pulse rate gradually decreased to 78 at the time of discharge. Respiratory rate was maintained at a range of 18 to 22 per minute. The temperature became normal within 12 hours. The patient produced considerable amounts of tracheobronchial secretions for the first six to eight hours and required frequent suction. Central nervous system stimulants were not given except for half a Gram of caffeine sodium benzoate administered intramuscularly.

Two hours after admission, the patient began to move spontaneously, although he remained unresponsive even to painful stimuli. Twelve hours after admission, he responded spontaneously and talked frequently, although he had slight nausea and was somewhat lethargic. He then gradually recovered the use of all of his faculties and became completely asymptomatic 12 hours after admission. On the third day of hospitalization the blood sugar was 96. The patient was discharged four days after admission.

Electrocardiograms: The electrocardiogram taken on admission revealed rhythm of regular sinus origin with an auricular rate of 125 and a ventricular rate of 125. The PR interval measured 0.12 seconds, the QRS interval 0.06 seconds and the QTc 0.30 seconds. The electrical axis was within the normal range and the electrical position intermediate. Lead I was normal throughout. Examination of Lead II revealed a diphasic T wave, with a slight depression of the S-T segment. In Lead III, the T wave was inverted, with slight depression of the S-T segment. Leads aVr and aVl were normal. In aVf the T wave was diphasic with slight depression of the S-T segment. Leads V1, V2, V3 and V4 did not show any abnormality. In V5 and V6 the T wave was inverted. When this tracing was compared with the one taken several days before admission it was apparent that the S-T segment and T wave changes were of recent origin. A cardiogram taken on the day following admission, when the patient had recovered, revealed that the T waves in Leads V5 and V6 had returned to the upright position, with disappearance of the S-T segment deviations noted in aVf, Lead II and Lead III. The T wave in Lead II and aVf still showed some decrease in amplitude.

A tracing taken several days after discharge showed return of the electrocardiogram to the normal pattern present before admission.

According to information received from the manufacturers,[2] they have reports (in part incompletely documented) on 23 patients (excluding our own) who, in suicide attempts, ingested overdoses of methyprylon ranging from 0.8 to 20 Grams. The ages of these patients (18 of whom were women) ranged from 24 to 64. With the exception of Reidt's case[1] all these patients made uneventful recoveries. Reidt's patient[1] ingested 6 Grams of methyprylon—a dose which is less than one-third of the highest dose known to have been taken without a fatal outcome. It is also worthy of note that the respiratory depression, present on admission of Reidt's patient, disappeared with time and that methyprylon was not demonstrable in the blood taken at autopsy.

Table 1 lists some of the data of our own case, of that reported by Reidt[1] and of the eight patients whose physicians granted us permission to review their protocols and to include summaries of their findings in this report.

As is seen, overdoses of methyprylon produced degrees of central nervous system depression which ranged from drowsiness (Case No. 10) to deep coma (Cases No. 6, 7 and 9). One patient (Case No. 1) became excited, but she apparently was a codeine addict.

The overdoses of methyprylon probably depressed respiration in more patients than those for whom low respiratory rates were recorded (Cases No. 2, 4 and 9) because depth of respiration must also be taken into consideration. For instance, in our patient (Case No. 6) the respiratory rate was 18—yet his breathing was definitely impaired since respiratory depth was shallow.

The overdoses of methyprylon had marked hypotensive effects in only two instances (Cases No. 7 and 9).

In all cases therapy consisted chiefly of supportive measures. In addition, the patient reported by Reidt (Case No. 7) was given stimulants and arterenol (Levophed®) bitartrate and the one observed by Smith[9] (Case No. 9) was treated with various stimulants.

The patient reported by Jones[5] (Case No. 3) is of interest because she was 3½ months

TABLE 1. TEN CASES OF METHYPRYLON (NOLUDAR®) INTOXICATION

Case No.	Reporting Doctor(s)	Patient's Age	Patient's Sex	Methyprylon Dose (Gms.)	Patient's State of Consciousness‡	Resp. Rate‡	Temp.‡	Pulse Rate‡	Blood Pressure‡	Treatment	Outcome
1*	Gilbert [3]	60	F	1.6	excited	16	98.0	80		supportive	recovery
2	Hoffman [4]	34	F	2.4-3.0	semi-comatose	12	—	64	120/20	supportive	recovery
3	Jones [5]	31	F	0.8†	groggy	20	—	80	100/20	supportive	recovery
4	Judd [6]	37	F	1.0	comatose	14	—	70	120/80	supportive	recovery
5	McDaniel [7]	45	F	2.6	slightly stuporous	20	98.8	82	140/90	supportive	recovery
6	Pellegrino & Henderson	45	M	3.4	deeply comatose	18	101.5	104	130/80	supportive	recovery
7	Reidt [1]	64	M	6.0	deeply comatose, shock	20	96.0	72	80/56	stimulants, levophed, supportive	death
8	Sisson [8]	45	F	1.2	drowsy	20	98.6	90	160/80	supportive	recovery
9**	Smith [9]	52	F	4.0	deeply comatose shock	4-6	97.0	80	44/18	stimulants, supportive	recovery
10	Wall [10]	27	F	4.6	depressed, drowsy	18-20		96	140/100	supportive	Recovery

* Dose unknown, but at least 0.8 Gm.—patient 3½ months pregnant
‡ On admission

* Also took 75 mg. chlorpromazine
** Also took 120 grains Tuinal®

pregnant. The moderate overdose of methyprylon did not produce any ill effects other than slight grogginess.

COMMENT

THE clinical picture of methyprylon intoxication is similar to that of barbiturate poisoning. Thus, symptoms may include depression of consciousness or occasionally excitement; shallow respirations sometimes associated with a decrease of respiratory rate; hyperpyrexia (as in our own case) or temperature below normal; and decrease of blood pressure which may lead to acute hypotensive states.

Goodman and Gilman [11] state that the fatal dose of barbiturates "varies with many factors and cannot be stated with certainty, but when over 15 to 20 times the ordinary hypnotic dose has been absorbed, severe poisoning will ensue and even expert therapy may fail to save the patient's life." In the case of the more commonly employed barbiturates this would correspond to 2 Grams.

Since, by weight, the sedative-hypnotic power of these compounds is two to three times that of methyprylon, it is reassuring that 23 of the 24 patients who ingested overdoses of methyprylon of up to 20 Grams (100 times the hypnotic dose) made uneventful recoveries. The fact that such a large dose as 20 Grams was not attended by a fatal outcome, bears out the opinion expressed by the Council on Pharmacy and Chemistry, American Medical Association [12] that methyprylon "possesses a wide margin of safety." This may be due to the fact that methyprylon exhibits less tendency to produce respiratory depressions than barbiturates, as has been reported by others. Thus, Stanton and Keasling [13] demonstrated that the effect of methyprylon-morphine combinations and that of methyprylon alone on respiratory minute volume of rabbits do not differ significantly, but that pentobarbital (Nembutal®)-morphine combinations are significantly more depressant than pentobarbital alone at low doses of this barbiturate. Similarly, Lardy [14]

showed that methyprylon did not significantly affect respiration and oxidative phosphorylation in mitochondria of rat liver, kidney and brain in several substrates, but that amybarbital (Amytal®) depressed these processes with all substrates, except in experiments with rat brain mitochondira in succinate substrate. It may be concluded that there is a difference in the mechanisms of action of methyprylon and of the barbiturates at least in the experimental animal and in *in vitro* studies.

The information available on the course of patients with methyprylon poisoning suggests that treatment should consist primarily of supportive measures similar to those used in the management of barbiturate overdosage. These may include maintenance of an adequate airway by aspiration of mucus from the mouth and pharynx, by insertion of an endotracheal tube or performance of tracheotomy; administration of oxygen and of artificial respiration, as needed; maintenance of adequate blood pressure; maintenance of adequate fluid, electrolyte and nutritional balance; and careful nursing care.[17,18]

Performance of gastric lavage is indicated even if the patient is seen many hours after ingestion of the drug. In fact, it has been our experience with most types of poisoning that one should not rely on any time limit to exclude performance of lavage. The safest procedure always is to wash the stomach and examine the contents chemically for the suspected toxic material. Except in unusual circumstances analeptics such as picrotoxin and pentylenetetrazol (Metrazol®) should be avoided. It would be interesting to determine whether β,β - methylethylglutarimide (Megamide®), which according to Shaw and associates [15,16] possesses specific properties of barbiturate antagonism, has a place in the treatment of methyprylon poisoning.

An interesting feature of our case was the changes which occurred in the electrocardiogram. As was shown, these consisted chiefly of changes in the S-T segments and T waves. Holzmann [19] reported changes, similar to those we observed, which occur with barbiturate overdosage, as well as with chloroform, ether and hexobarbital (Evipal®) sodium. Therefore, these effects certainly are not specific for methyprylon and may well be due to anoxemia or to some effect on myocardial metabolism.

SUMMARY AND CONCLUSIONS

1. The case of a 45-year old patient is presented, who, in a suicidal attempt, ingested 3.4 Grams of methyprylon (Noludar®). He was deeply comatose and respirations were shallow. A gastric lavage was performed and supportive measures were instituted. The patient became completely asymptomatic 12 hours after admission. The changes in the S-T segments and T waves of electrocardiographic tracings taken on admission returned to the normal pattern, present before admission.

2. Information on additional 23 patients who ingested overdoses of methyprylon is briefly reviewed. This number includes one fatality.[1] The symptomatology and treatment of the latter patient, of our own patient and of the eight patients whose physicians granted permission to include summaries of their findings in this report, are discussed.

3. It is suggested that a difference in the mechanism of action of methyprylon and of the barbiturates, observed by other workers, is responsible for the wide margin of safety of methyprylon.

4. The importance of physiologic treatment of depressed respiration and circulation in patients with methyprylon intoxication is stressed.

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Bibliography will appear in authors' reprints

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Sex Murder and Sex Aggression

"Life is short" said Hippocrates, "art is long, the occasion fleeting, experience fallacious and judgment difficult." How to prognosticate a potential murderer when asked to examine a minor sex deviant? Dr. Revitch has no answer to this, but he offers a few useful criteria.

Two recent sex murders in New Jersey aroused public and official concern about our ability to prognosticate sexual violence. Although *aggressive* sexual acts make the headlines, initial studies by Brancale [1] and others [2,3] confirm what seems to be the impression of psychiatrists working in the field: that the majority of sex offenders are innocuous, inadequate, passive individuals committing minor offenses. Exhibitionism, dissemination of obscene material, non-coital relations with immature boys and girls and statutory rape are the most frequent sex offenses referred by the courts to the New Jersey State Diagnostic Center. Although Karpman [4] quotes Hartwell by saying that many sex murders of children are committed by pedophiles, Brancale [5] in his extensive experience saw only one such case. In my own experience the only case was that of a fifteen-year old boy murdering a six-year old girl during or after rape. As a matter of fact, the true pedophiles belong to the most passive group of sex offenders and their acts consist in non-coital relationship with children such as kissing, touching, fingering genitals of little girls and the like. Furthermore, Rogers and Weiss [6] found that in many instances, "victims" are such in the legal sense only, since due to their own emotional needs, they induce the emotionally inadequate pedophiles into sexual play. This study confirms my personal clinical impression. Davidson [7] points out that aggressive sexuality may manifest itself in symbolic acts of non-sexual nature such as pyromania, or sexual motives may be elicited in general crimes such as murder. It is not too uncommon to encounter dangerous sexual compulsions under the guise of common crimes.

For the sake of this study the aggressive expressions of the sexual instinct will be divided into four groups:

(1) Murder is the pre-requisite of sexual satisfaction.
(2) Murder is not a pre-requisite for sexual satisfaction but is due to frustration, anger or fear during an attempt at intercourse or rape.
(3) The aggressive sexual needs are expressed in knifing, slugging or choking, with or without ejaculation during the act.
(4) The aggressive sexual needs are expressed in phantasy life only.

1. Brancale, Ralph, Ellis, Albert, and Doorbar, Ruth: American Journal of Psychiatry, 109:17 (1952).
2. Ellis, Albert and Brancale, Ralph: *The Psychology of Sex Offenders*. Charles Thomas, Springfield, Ill. 1956.
3. Brancale, Ralph: Personal communication
4. Karpman, Ben: *The Sexual Offender and His Offenses*. Julian Press, New York, 1954.
5. Brancale, Ralph: Personal communication
6. Rogers, Estelle and Weiss, Joseph: California Sexual Deviation Research, State of California Department of Mental Hygiene. Sacramento, Calif., 1954.
7. Davidson, Henry A.: *Forensic Psychiatry*. Ronald Press, New York, 1952.

These four categories are not fixed. History is replete with cases in which unprovoked assaults, beatings or chokings eventually transform into repetitive murders of group 1. In some instances these murders are preceded by a long history of disorganized behavior. Murders in group 1 connected with mutilation of the body and even anthropophagy (eating of human flesh) have been reported in psychiatric literature by authors of the last century.[8] One of the outstanding cases is that of Vincenz Verzeni, examined by Lombroso and quoted by Krafft-Ebing.[8] Verzeni was arrested in 1872 at the age of 23 years for an attempt to strangle his nurse while she was lying sick in bed, and also for similar attempts on three other women. After his arrest it was discovered that he had killed a fourteen-year old girl, mutilated her body, tore out her intestines and genitals, bit off a piece of flesh from the right calf and sucked the blood from the wound. He had strangled a twenty-eight-year old woman and ripped out her intestines. He had dragged his nineteen-year old cousin into the fields and tried to choke her. He took a portion of flesh from one of his victims home to roast and eat, but later he changed his mind and hid it, since he was afraid his mother might discover his behavior. After his arrest Verzeni explained that he had an "unspeakable delight" in strangling women and that during the act he experienced erection and ejaculation.

That repetitive killing of victims may be preceded by abnormal aggressive behavior is well illustrated in the case of Heirens,[9] a seventeen-year old student who killed two women and then kidnapped a six-year old girl and dismembered her body. At the age of nine, Heirens began stealing female undergarments. Later on he committed burglaries originally to obtain female undergarments and later because of a sexual thrill accompanied with ejaculation while he entered a home through the window.[9] He struggled against the impulse to burglarize and later on to kill. His attempts to fight the impulse produced anxiety with sweating and headache. With the lipstick of one of the victims he wrote on the mirror, "Catch me before I kill again. I can't help myself." Eugene . . . described by Guttmacher[10] killed with a knife two eleven-year old girls while on parole serving a sentence for attacking several women with a penknife. The sexual nature of his attacks apparently had not been recognized by the court and he was treated like a common criminal just serving a sentence for assault.

One of the New Jersey cases was examined at the State Diagnostic Center by Dr. Ralph Brancale five years prior to the murder of the victim. He was known then to have perpetrated the following acts: he set fires, he cut his mother's underclothes, he broke into a neighbor's house and wrecked several rooms. A year after this examination he molested two little girls and stuffed cleansing tissue in their mouths. While the sex murders in Group 1 are of compulsive nature and very likely more murders or assaults will be perpetrated if the murderer is not apprehended, the murders in Group 2 are basically accidental and usually committed in a state of frustration, fear and anger connected with the offender's inability to perform the sexual act or with his feelings of impotence and inadequacy. The following case examined by the author in one of the New Jersey prisons will illustrate this mechanism:

CASE ONE

A forty-year old, unmarried, weak, inadequate chronic alcoholic with a deep feeling of inferiority and with potency disturbances, was drinking with his friend in a tavern. There they met a woman who agreed to follow both men into their car. She refused to have sex relations with our patient. He hit her head and body with his fist. When she lost consciousness, both men took her to a motor court and put her to bed. Our patient climbed on top of her and attempted intercourse but was unable to obtain an erection. He fell asleep. He found her dead the next morning, and turned himself in to the authorities.

8. Krafft-Ebing, Wolfgang: *Psychopathia Sexualis*. Translated by Gar Nicht. Physicians and Surgeons Book Company, Brooklyn, N. Y., 1934.

9. Freeman, Lucy: *Before I Kill Again*. New York 1956. Pocket Books, Inc.

10. Guttmacher, Manfred S.: *Sex Offenses: The Problem, Causes and Prevention*. Norton, New York, 1951

Another case examined by the author at the Diagnostic Center illustrates the influence of fear in sex murders belonging to Group 2.

CASE TWO

A fourteen-year old boy attempted intercourse with a six-year old girl. Since he could not effect penetration he forcibly proceeded to have anal intercourse. The girl fainted. He became frightened and hid her in a pile of automobile tires where she died from asphyxiation.

The Group 3 can be best illustrated by the following case.

CASE THREE

A forty-year old single male, inmate of one of the New Jersey prisons, was serving a sentence for assault and battery at the time of the examination. He had clubbed a young woman on the street. He pulled her into his car. Her screams brought rescue so that he was forced to run away. Upon arrest the police found in his room and in his car blackjacks, a knife, a rifle, a noose, pornographic pictures and a volume of *Psychopathia Sexualis* by Krafft-Ebing. He had a good army and work record, was never arrested prior to the offense. He did not drink and in general enjoyed a good reputation. He said that the girl had been clubbed in an attempt at robbery. Under sodium amobarbital* injected intravenously he revealed the following.

At the age of nine years he tied a little girl's legs. When she screamed and kicked he experienced a "peculiar thrill." Since then he has always been thrilled by pictures or motion pictures in which women were tied by savages in the jungle. He frequently phantasied about tying women's legs. He satisfied his urge just by looking at pornographic pictures. While in service he corresponded with a girl whom he intended to marry. After discharge he disrupted the relationship, rationalizing his celibacy by the duty to support his aged mother. Although he associated with others, he basically was withdrawn, had a feeling of loneliness and isolation. Under sodium amobarbital* he said the following: "I tied her legs because I wanted to feel that she was my own, that she was close to me. I don't want to hurt people (cries bitterly). During the robbery I wanted to hit a girl's head, and at the same time I wanted to soften the hitting, since I didn't want to hurt her (cries). I didn't want to do it. I tried to hold my own hand. I was scared, I was afraid that I'd hurt her."

There is evidence in literature that simple assaults on women may presage sexual killing. To illustrate this view I will cite shortly several cases. (1) Eugene . . . described by Guttmacher [10] assaulted women with a knife prior to stabbing to death two little girls. (2) Roche, arrested in New York City for inflicting stab wounds on a fourteen-year old girl, had at the time a record of five murders. According to the newspaper reports he said "sex entered his life when he was sixteen and that he forced himself on girls with a knife." (3) Bruno . . . described by Magnus Hirschfeld [11] impulsively choked a prostitute to death. While she was lying inert he attempted intercourse with the corpse, but could not obtain erection. He then stabbed the body and later proceeded to choke the victim's mother. Prior to this crime he grabbed another woman by the throat, but when she fell to the ground he became terrified and asked her forgiveness. One of the sex murders committed recently in New Jersey by an eighteen year-old boy was preceded by assaulting two little girls, stuffing their mouths with tissue paper as well as destruction of female clothing. In the other sex murder case committed by a twenty-three year old male, history shows that at the age of fourteen years he threw a nine-year old girl to the ground, exposed himself and attempted sodomy. Case 3 reported above tied little girls' legs at the age of nine years and has frequently phantasied about it since then. The list of such incidents preceding murder is impressive. This, however, poses a very serious prognostic problem since incidents of sudden unprovoked assault on women or sadistic phantasies are fortunately more frequent than the ultimate murder. The following case will illustrate the responsibility of a psychiatrist when he is called to examine this type of behavior.

CASE FOUR

A thirty-five-year old male was serving a short prison term for larceny. Consultation was requested since the custodial officers found, in his cell, drawings of torture and murder of women in medieval

*We used the Lilly brand of amobarbital which they tradename as Amytal®.

11. Hirschfeld, Magnus: *Sexual Anomalies and Perversions.* Translated by Phineas Fogg. Emerson Books, New York, 1944.

dungeons as well as hundreds of scribbled pages of horror stories, all products of his own genius. A sample of his writing will illustrate the extent of his sadistic phantasies: "A naked man hung swinging and writhing by his genitals. Next to him hung a plump woman who had cords threaded through her breasts and she was hanging by them. The weight of her body pulled them up by her face. It was a pitiful sight as she writhed and squirmed. The mob was jabbing sticks at her buttocks and vagina while she hung there writhing."

The prison authorities wanted a prognosis of this man's behavior. He obviously had sadistic phantasies, his personality was somewhat disorganized and characterized by schizoid traits. Yet there was no history of violence of any kind. In another case a sixteen-year old boy surrendered to the police saying he was afraid to choke his girlfriend. It appeared during a sodium amobarbital* interview that he made several such attempts and that he frequently phantasied of seeing his mother dead in a coffin. He was failing in school, felt lonely, isolated and rejected.

Another seventeen-year old boy fell asleep riding the bus, and when he woke up he found himself at the end of the line. A young woman descended with him and when both crossed the street he suddenly struck her and threw her down without provocation.

Shall we commit all these cases as potential sex murderers? Have we enough data to predict sexual murder? The answer is no. The best we can do is to be suspicious of such a possibility. Much more coordinated clinical research in the field is necessary. Unfortunately most of the cases, although reported in the press, are not thoroughly examined and reported in the professional literature.

Prognosis should be based on a combination of (1) History of assaults on women or girls. (2) Dislike and resentment of the opposite sex. (3) Sadistic phantasies. (4) Sexual preoccupations, particularly fetishism of female underclothing. (5) Schizoid traits or well defined schizophrenic process. Undoubtedly many of the sex murderers reported in the press and literature are well integrated paranoid schizophrenics who do not impress many examiners as being psychotic. As far as the psychodynamic factors leading to sexual violence are concerned, it is my opinion that in cases belonging to Groups 1, 3, and 4, there is a resentment of maternal figure transferred to womanhood in general. The following case illustrates this point.

CASE FIVE

A twenty-six-year old male picked up a forty-five-year old woman in a tavern, took her in his car and drove to an isolated place. Both undressed and after completing intercourse she told him she was supposed to go to the hospital for a checkup. It flashed through his mind that his mother had just come home from the hospital. He then suddenly put his hands on her neck and with the words "Go and die there, bitch," he strangled her. On projective tests he referred to women as "whores." He also revealed repetitive dreams of chasing naked women up a tree and of being the master of a "whorehouse." A great deal of hostility to his mother was also expressed.

This man was a pantie fetishist. He bragged of having collected 185 pairs.

Davidson[7] says that there is some evidence that public clamor, gruesome and sadistic pictures as well as newspaper reports, may stimulate sadistic acts. Marshall Gilles de Ray of France, executed in 1440 for murder and mutilation of eight hundred children, said that he was stimulated by the accounts of orgies of the Roman emperors. In my own experience at least two individuals reported here asserted that they were stimulated by pictures and horror stories.

SUMMARY AND CONCLUSIONS

EXTREME manifestations of sexual violence are relatively rare. The majority of sex offenders commit minor crimes of non-aggressive nature. There are four types of sexual violence. (1) Murder is a prerequisite of sexual satisfaction. (2) Murder is committed in a state of fear or anger connected with frustration. (3) Sexual satisfaction is connected with aggressive acts against women such as stabbing, clubbing or choking. (4) Sadistic needs are expressed in phantasy only. There is evidence that many instances of compulsive sexual murder were preceded by manifestations belonging to type 3.

Prognosis is difficult, and not enough detailed studies are available.

A combination of aggressive acts against women, hatred of the opposite sex, hostility for maternal figure, sexual preoccupations and schizoid traits should alert the examining physician to the possibility of sexual murder in the future. These traits or acts should not be dismissed lightly even when performed by children.

When one encounters an adolescent with all these factors, unless he is manifestly psychotic, there will be reluctance to deprive him indefinitely of liberty, since no one can be certain that such an act will be committed. If no crime is committed they will not be accepted by penal institutions. If they are not notoriously psychotic, they will not be kept in mental hospitals. Institutional treatment of suspects is not available and the value and limitations of psychotherapy has not been evaluated yet. Karpman [4] asserts that no sex murderer has ever been analyzed. Besides, the families of the suspects may be unable to afford or unwilling to accept private or clinic treatment. The patient may live too far away from the nearest clinic or clinic facilities may be insufficient.

Public clamor to do something about this can be satisfied only in the following ways: (a) More clinical research. (b) More exchange of information through publication in scientific papers of cases that come under the attention of psychiatrists. (c) Impressing upon courts the necessity to refer for psychiatric examination all the cases of compulsive assaults on women. (d) The family physician's understanding that he should not dismiss violence of children against girls, particularly when it is connected with sexual preoccupations as childish pranks. Instead he should request a psychiatric consultation.

The Diagnostic Center

Musicians vs. Dentures

A brass instrument player with dentures can continue his career but in a capacity limited by the principles of physics involved in maintaining a denture in position, reports Dr. Joseph L. Sevigny.*

"He is able to meet the requirements of small musical groups (four to six instruments) where volume, accuracy and extremely high notes are unessential. He can also play second and third chair in an orchestra. He will have to content himself with considerably less than his former ability," the dentist explained. "If he thinks he can fulfill the requirements of really fine playing, such as are required in our better orchestras, he is deceiving himself."

The author, a practicing dentist who has played trumpet for 40 years, explained that he has measured pressures which are built up while playing trumpet. While not playing a gauge can be made to show three pounds of pressure, and while playing "sometimes we will use nearly a pound of pressure." This added pressure is required to play high notes.

"This same amount of pressure is all that is needed to rise the posterior palate and break the seal of our denture," he continued. "I have prevented loss of teeth for many brass instrument players. We must know what not to do as well as what to do in these cases."

*Sevigny, J. L.: *Oral Hygiene* 47:52 (April) 1957.

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Geriatric Dermatology*

Skin diseases especially prominent at the senium are allergic dermatitis, cutaneous manifestations of visceral malignancy and a variety of benign and malignant new growths. Dr. Nicholas competently reviews the diagnosis, prognosis and management of the dermatoses peculiar to, or common in the aged.

"Geriatric dermatology" covers all phases of dermatology which are met in the aged skin, as well as all cutaneous alterations brought about by aging. Lansing[1] has defined aging as a process of unfavorable progressive change, usually correlated with time, becoming apparent after maturity, and terminating invariably in death of the individual. The process cannot be accounted for by a failure of organ systems, for all multinuclear living things share the common fate. No relationship has been found between the average length of life of the individuals composing a species and any fact of life history, structure, or physiology. Natural death is a new phenomenon in evolution, occurring necessarily only in multinuclear animals, although some protozoa do age and die. The somatic death of higher organisms is a price paid for specialization of structure and function.

While the senile skin is subject to many diseases seen earlier certain ones occur predominantly at this time. These include: (1) A variety of new growths (senile freckles, seborrheic keratoses, senile keratoses, hard nevi, senile sebaceous adenomas, cutaneous tags and senile angiomas); (2) various forms of allergic dermatitis; and (3) cutaneous manifestations of visceral malignancy.

Each of these topics is discussed below. Several other subjects, equally vast, such as cutaneous malignancy, atrophic and hypertrophic lesions of the skin and mucous membranes, and psychosomatic dermatoses will not be discussed. They are more than adequately covered in the papers by Waisman,[2] and Ormsby.[3]

ANATOMY

The principal anatomic and physiologic characteristics of aging of the skin are manifest in a variety of ways in the different layers of the skin.

The *stratum corneum* of senile skin reflects abnormalities of keratinization which are of much clinical significance. In general, the horny layer of the older person is thinner and parchment-like, although some areas show hyperplasia in the form of marked keratotic and opaque thickening. Visible scaling of the skin is usually more marked in an elderly person than in a young individual. Decreased sebaceous secretion may be a factor in producing this dryness and visible scaling, but it appears that dehydration is more important than defatting. The water content of the stratum corneum is probably lower in the older person. This may be related to changes in the surface

*Read before the Section on Dermatology, at the Annual Meeting, The Medical Society of New Jersey, Atlantic City, N. J., April 30, 1957.

lipids and to a resultant decrease in its water-holding capacity. The practical or clinical significance of this observation [4] lies in the treatment of "dry skin dermatitis" which is so common in older patients. This dermatosis may appear as well defined, reddened and scaling plaques on the outer surfaces of the thighs and arms, or as poorly defined rough areas of chapping, in which large polygonal scales are outlined by a criss-cross of red lines. Patients with 'dry skin dermatitis" are best treated by tepid baths to restore moisture in the surface epithelial cells, and immediately following the bath, the patient should apply a film of any kind of grease so as to retard evaporation. Although high potency vitamin A has been recommended for "dry skin dermatitis," I am not convinced that it is of real value in this condition.

The epidermis appears thin and the interpapillary pegs are flattened in the routine histologic section of aging skin. However, evidences of epidermal hyperplasia may be marked in some areas.

All of the *skin appendages* show evidence of decreased function in old age. The *eccrine glands* suffer a gradual reduction of function at a variable rate. The *apocrine glands* undergo atrophy at the menopause. The *sebaceous glands* become smaller and less active, although adenomatoid sebaceous hyperplasia and comedones are frequently encountered in older people. The *hair follicles* are fewer and less prominent. The hair on the eyebrows becomes bushy. The hair of the nasal orifices and ears frequently becomes bristly, coarser, and attains greater length in older men.

The senile nail has certain characteristics which differentiate it from the ordinary mature nail.[5] These features are dullness, opacity, increased longitudinal ridging, changes in color and thickness, and masking of the lunula. Microscopically, the nail may show ridging, changes in thickness, terminal splitting, and peculiar calcification patterns. The number of pertinax bodies, which are retained shrunken nuclei with perinuclear eosinophilic material or vacuolization, may be increased in the aging nails. These have been interpreted incorrectly as characteristic of psoriasis or onychomycosis. The nail exposed to excessive roentgen radiation bears a resemblance to the senile nail.

The *corium* decreases in thickness with loss of elastic and collagen fibers. The collagen fibers become thin. The elastic fibers become increasingly amorphous. The result is a corium which is structurally less firm and less elastic. The skin appears grossly thinner and the underlying blood vessels appear more prominent. The wrinkling so characteristic of aging is related to the thinness of the skin, its loss of elasticity, and the lessened firmness of support from the cutis and subcutaneous tissues.

The *subcutaneous fat* is commonly decreased in the aged. As a result of this decreased subcutaneous padding, the already thin and more vulnerable senile skin often has inadequate cushioning to withstand the external physical traumatic experiences of daily living.

CLINICAL GROUPS

Disorders of pigmentation are characteristic of senile skin. As the individual grows older, it is common for him to develop more and more areas of discoloration, some flat, others elevated, with colors ranging from red to yellow through gray to brown or black. It is important for the physician to familiarize himself with the characteristic features of these lesions so that he may readily differentiate the benign ones from the premalignant or malignant growths. With a public that is cancer-conscious and being trained to submit to periodic cancer detection examinations, the physician is often required to recognize and treat many cutaneous lesions without histologic study. Biopsy and microscopic examinations are needed in more cases than those in which they are now routinely performed. Yet many lesions, such as typical seborrheic keratoses, may be removed with far less scar formation and less extensive surgery, if they are immediately recognized.

Senile freckles are large, irregular, dark-tan or brown macules which appear in exposed areas of the skin. They are especially noted on the hands, forearms, face, and neck. With the

exception of the very rare senile freckle which turns black and results in a melanoma, these brown stains are harmless. The fact that they need no therapy is fortunate, since excision is usually not practical and topical applications are usually of little permanent help.

Seborrheic keratoses or seborrheic warts, make their appearance at any time but usually they develop in the later decades of life. They occur chiefly on the trunk and arms, but not uncommonly on the neck and face. They have the appearance of a drop of dirty wax "stuck on" the skin. The color varies through various shades of light-yellow to dark-brown. The surface may be smooth or warty. The lesions have neither induration nor an inflammatory base, both of which are characteristic of senile keratoses. In the rare case in which malignancy ensues, the lesion becomes soft and friable.

These growths respond readily to fulguration and curettage with practically no scarring since they are so superficial—they do not extend below the level of the epidermis. Biopsy is indicated only in the rare case which is irritated or infected, so that malignant degeneration can be definitely excluded. Wide excision as often practiced by so many general surgeons is likewise not indicated for this usually benign and harmless cosmetic defect.

Senile keratoses occur more often in people past sixty years of age and are seen chiefly over the temples, other parts of the face, ears, sides of the neck and dorsal surfaces of the hands. In other words, the sites of predilection are the areas of skin repeatedly insulted by the sun and wind. Senile keratoses are usually flat, moderately elevated, and have a firmly adherent dark scale. This outer coating may be tissue-paper thin or so thick as to form a cutaneous horn. A rapid increase in keratinous material or the formation of an indurated base may be an early sign of malignant degeneration. Squamous cell epithelioma (beginning as epithelioma *in situ*) develops in fewer than 20 per cent of the cases of senile keratoses studied histologically, which means a much smaller proportion of all senile keratoses undergo malignant change.

All senile keratoses should be destroyed. The method is not important, provided the destruction is complete. Surgical excision is preferred because it affords ample material for histologic study. If a biopsy is not possible, effort should be made to get tissue for histologic study whenever there is inflammation or induration of the base, erosion or ulceration of the surface, or a change of consistency to a very friable tissue with increased vascularity. In short, any change may be evidence of malignancy and microscopic confirmation should be obtained. Electro-surgery, cauterization, thorough curettage, cryotherapy, and radiotherapy will give comparably good results if the operator is trained in the use of the method.

Hard nevus (Unna). Unna[13] described a type of hard nevus which usually appears symmetrically in groups on the backs of the hands and feet, in the latter decades of life. Removal of the granular verrucous surface is followed by recurrence of the papule. These nevi are often associated with senile freckles and are not infrequently confused with senile keratoses, seborrheic keratoses, flat warts and even common verrucae.

Senile sebaceous adenoma is a common benign disorder in people past middle age. It occurs chiefly on the forehead in the form of small, cream-colored or yellow, translucent, often umbilicated papules. Microscopic examination is often indicated to exclude the erroneous clinical impressions of xanthoma and basal cell carcinoma. Histologically, the acini appear normal but the sebaceous glands are hypertrophic. Any destructive procedure is good therapy.

Cutaneous tags are found in many elderly people. These are soft, pedunculated, pinhead- to pea-sized cutaneous tags hanging in the axillae, on the sides of the neck, on the back and on the eyelids. They are usually flesh-colored, shaped like tear-drops, and when palpated feel like little bags. They are harmless, but occasionally one will become inflamed, tender, and gangrenous following the twisting of its pedicle. These tags are known by a variety of names which include papillomas, soft fibromas, soft warts, and achrochordon. These growths may be clipped off with small scissors, with or without anesthesia, depending on

the individual patient's pain threshold.

Senile angioma is a small, bright-red or purplish area resembling extravasated blood but consisting of tufts of dilated capillaries. They are seen on the trunk and upper parts of the chest of aging patients, and are also known as senile ectasias, ruby spots or De-Morgan spots. They should not be confused with the vascular spider (nevus araneus) so often seen in pregnancy and liver disease. These lesions are readily removed by electrolysis, solid carbon dioxide, or electrocoagulation.

ALLERGIC SKIN DISEASES

THE term "allergic dermatoses[6]" usually refers to the following dermatologic entities:

Allergic eczematous contact dermatitis occurs less frequently in older people than in younger people principally because of three factors: (1) relative lack of exposure to certain agents, (2) reduced susceptibility to sensitization, and (3) loss of many allergic contact sensitizations with advancing age. Even during the acute stage, allergic contact dermatitis in aging skin produces relatively little inflammation. In the subacute and chronic stages the scaling is especially pronounced. It seems as though some of the most common allergens of young people, such as plants, are much less important in the older people. On the other hand, dermatitis from certain air-borne allergens, such as ragweed pollen oleoresin, appears to be more common. Older people may get contact dermatitis from cosmetics used to mask the stigmata of advancing age, from topical medicaments, from materials used in hobbies to which they turn after retiring. A carefully recorded history and observation of the distribution of the eruption will usually permit the physician to find causal agents. Patch tests may be of great help, but they must be performed according to standard technics. The treatment is no different in the aged patient from what it is in any other age group.

Allergic drug eruptions are seen rather frequently in people over fifty, perhaps because many of them require medications or because they have acquired the habit of taking drugs. Too often, in searching for the cause of an eruption, only "new" drugs or new combinations of drugs are suspected. "Old" drugs, however, taken regularly for months or years must also be considered suspect. No one knows the reasons for allergic sensitization to drugs taking place suddenly after years of non-injurious exposure. Tentative proof is obtained when continued avoidance of a drug is followed by definite improvement within a few days to several months. Final proof can be obtained only when the re-administration of the suspected drug causes recurrence. It is obvious that in order to avoid unnecessary suffering or dangerous reactions, such re-administration should be carried out only if it is essential to have this proof. Re-administration of the drug, is, of course, strictly contra-indicated in severe manifestations such as anaphylactoid reactions, exfoliative dermatitis and laryngeal edema. Symptomatic topical and systemic treatment is important, but only secondary to the elimination and avoidance of the causal drug. Occasionally, as in cases of allergic insulin hypersensitivity, it may not be possible to withhold the drug. In such cases, one should try to change to a different type or a different compound of the same drug, or possibly one prepared from a different animal species. Specific hyposensitization, generally not practicable in treatment of drug eruptions, has been reported as successful in some cases of cutaneous allergy to insulin, penicillin, liver extract, and sulfonamides.

Acute urticaria which lasts from a couple of hours to a couple of weeks, is not common in people over fifty, probably because most people of this age have discovered the foods, commonly used drugs, and other substances which tend to cause acute urticaria. On the other hand, *chronic urticaria* is a major dermatologic problem in patients over fifty. Such factors as drugs, foods, foci of infection, intestinal parasites, inhalant allergens, physical agents, and emotional factors may be investigated thoroughly, but are actually incriminated in few cases. The co-existence of any disease of the leukemia-lymphoma group must be ruled out. By and large, a specific cause cannot be found in most cases of chronic urticaria.

The treatment of chronic urticaria is a challenge. After all of the "specific" measures (elimination of foods and drugs, drainage of foci of infection, and so forth) are unsuccessful, corticosteroids and ACTH are often tried. While large doses are helpful in some patients, they have not lived up to the original expectations and they certainly are not the answer to the nonspecific management of urticaria. Moreover, particularly in the older age group, the possibility of serious side effects cannot be overlooked. Ataractic agents control the urtication in some cases.

Atopic dermatitis rarely persists after the age of fifty.

Autosensitization dermatitis is another form of allergic dermatitis which affects the aging skin. The skin is sensitized to products of protein breakdown, although secondary infection, trauma, irritation by topical applications and other damaging influences may share the responsibility of causation. The allergens originate in a localized lesion, so often a chronic eczema of the leg, and they produce an extensive eruption with explosive force. The aging and aged patient seems to be more prone to develop this autosensitization dermatitis, and not infrequently he suffers from recurrent episodes, with each attack more severe and more extensive than the previous one. Corticosteroids and ACTH are great aids in bringing about involution of the disseminate lesions and often produce corresponding involution on the primary site. However, unless continued, careful, mild, non-irritating therapy is applied to the original area of dermatitis, exacerbations and recurrences will definitely follow.

THE SKIN IN VISCERAL MALIGNANCY

The skin is an important organ in the diagnosis of visceral malignancy. The skin may be involved by lesions related to the internal new growth long before the primary tumor is suspected. The cutaneous manifestations may be specific (that is, metastatic to the skin), or nonspecific (that is, cutaneous lesions associated with internal malignancy not of themselves malignant). For a discussion of the specific or metastatic reactions, see Beerman.[7]

The nonspecific cutaneous manifestations of visceral malignancy and of the leukemia-lymphoma group can be considered together. The latter were listed in an exhibit at the American Academy of Dermatology and Syphilology in 1954 by Bluefarb and Schwartz[8] as the eleven "P's":

1. Pallor
2. Pruritus, including urticaria
3. Prurigo-like papules
4. Pigmentation, including acanthosis nigricans
5. Pityriasis rubra or exfoliative dermatitis
6. Purpura, petechiae and other vascular phenomena
7. Pyoderms
8. Posterior spinal ganglionitis or herpes zoster
9. Pemphigoid or bullous lesions
10. Poikilodermatomyositis
11. Phlebitis

Acanthosis nigricans in the aging patient is the so-called malignant type. The cutaneous lesions are usually symmetrically situated in certain predilected areas: axilla, neck, genitalia and groin, to mention only the most common sites. The skin becomes deeply pigmented, the skin markings are intensified, and the surface becomes verrucous. The accompanying cancer is usually of the glandular type, originating in the abdomen in over 80 per cent of the cases. The other cases have extra-abdominal glandular growths or other forms of malignancy. The presence of the original tumor or metastatic tumor immediately beneath the area of acanthosis nigricans is extremely rare, but has been observed by the author.[9] Chronologically, the acanthosis nigricans and the cancer are independent; the skin lesions may appear before or after the tumor, but in most cases they develop simultaneously. The relationship between malignancy and the cutaneous change is obscure.

Exfoliative dermatitis is a reaction pattern rather than a disease entity. This reaction may be caused by a variety of conditions, the most important of which, in the aged patient, are psoriasis and seborrheic dermatitis, the internal and/or external use of drugs, mycosis fungoides or some other member of the lymphoma group, or internal malignancy. The patient with exfoliative dermatitis must be thoroughly studied so that an etiologic diagnosis may be made before the condition is considered idiopathic and corticosteroid or ACTH therapy is instituted.

Dermatomyositis has been found increasingly in association with adenocarcinoma.[9] Sheard and Knoepfler[10] recently reviewed the records of 14 patients with dermatomyositis, of whom 6 had an associated carcinoma. The internal malignancy may be in the gastrointestinal tract, the genital tract, or in the breast. In addition to the advocated medical treatment of dermatomyositis with corticosteroids and ACTH, any neoplastic process should be treated by operation or radio-therapy, either of which may be followed by regression of the dermatomyositis. Conversely, sudden intensification of the symptoms of dermatomyositis may correspond to the seeding of metastases. It has also been demonstrated that when death occurred, dermatomyositis and not malignancy was the cause in most cases.

Carcinoid tumors may be found in patients of any age, from ten days to eighty-nine years. Carcinoids primary in the appendix are usually found in younger people. In contrast, carcinoids primary elsewhere are usually found in older people, the average age of 453 reference cases being 55 years. Metastases have been found in almost every organ of the body.[11] Patients having the clinical features of a functioning carcinoid tumor were found to have an abnormal amount of serotonin in their circulating blood (hyperserotoninemia). They also excreted a large amount of 5-HIAA in their urine, and demonstrated a concomitant disorder of tryptophan metabolism.[12]

The principal cutaneous feature of the carcinoid syndrome is a characteristic flushing. It starts on the face and may extend to the chest, arms or legs. The flush may be momentary, but more commonly, it lasts seven or eight minutes. The spontaneous paroxysm, with rapid changes in appearance and color, is perhaps more striking and diagnostic than the actual changes of the skin itself. Unusual patches of cyanosis may develop in the flushed skin. The flushes may be only occasional, or may recur many times a day. In addition, these patients often develop a persistent reddish-purple discoloration of the face, looking as if they were plethoric, though the red cell count remains normal or is slightly reduced. As time passes, the patients become even more cyanotic, and telangiectasia becomes apparent in the affected area.

SUMMARY

PROMINENT among the changes of the aging and aged skin are new growths and localized pigmented lesions. The distinctive features of the more common benign and premalignant lesions are presented so that these new growths may be diagnosed more readily and treated more promptly.

The various forms of allergic dermatitis are described as they are altered by old age. The importance of autosensitization is stressed.

Attention is called to the cutaneous manifestations of visceral malignancy. Special emphasis is placed on acanthosis nigricans, exfoliative dermatitis, dermatomyositis, and the cutaneous aspects of functioning carcinoid tumors.

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Medical Aspects of Gastrointestinal Polyps*

Gastrointestinal polyps are common and seem to be getting commoner. Every family doctor should be aware of this, and should realize that some of these polyps become malignant. A case can be made for routine sigmoidoscopy for all adults over the age of 40. The specific danger signals are highlighted here in Dr. Silberner's paper.

Polyps can occur anywhere in the gastrointestinal tract. They are important in clinical medicine primarily because they have the potential of becoming malignant. They may produce symptoms which will alert the clinician; or, may exist for many years without symptoms, until malignant change produces local or systemic effects. This latter group presents a challenge to the diagnostician and requires an awareness of the problem. Every person past the age of forty years should be sigmoidoscoped at periodic intervals. Pernicious anemia or achlorhydria or familial history or unusual pigmentation about the mouth or unexplained bleeding from the gastrointestinal tract should suggest careful search for polyps by endoscopic and radiographic technics.

The name *polyp* is a clinical term which means any outgrowth from a mucosal surface into the lumen. It does not reflect the anatomy of the structure or its actual nature. Turrell[1] has stressed the importance of exact terminology, which would classify a polyp by its histologic structure and its mode of development. We should speak of polypoid adenoma or villous papilloma, benign or malignant growths, invasive or non-invasive. Confusing terminology, such as cellular atypism or carcinoma *in situ*, may be variously interpreted. A tumor should also be classified as truly neoplastic, inflammatory, or allergic.

Many polyps exist for an unknown period of time without producing symptoms. They may be discovered by coincidence, by routine examination, or by investigation of complaints of bleeding, pain, obstruction or indefinite digestive disturbance. The bleeding may be gross or microscopic and may be revealed only on routine chemical study of the stool. The pain is not characteristic but may be described as indefinite, uncomfortable, and is usually thought to be the result of some traction on the pedicle caused by peristalsis. If the polyp is particularly large, it may produce obstruction, intussusception, or both.

Stomach and Esophagus

In the esophagus, polyps are rare. Boyd[2] found two polyps in 13,460 autopsies at the Mayo Clinic and at the University of Chicago. Statistical data are difficult to obtain on the natural history of this lesion. When found, the growth can usually be removed endoscopically.

In the stomach, it is necessary to differentiate true polypoid adenomas from other growths. True neoplastic polyps are most commonly found in the presence of achlorhydria,

*Read before the Section on Gastroenterology and Proctology, The Medical Society of New Jersey, April 30, 1957.

91 per cent showing this finding in the series reported by Yarnis[3] *et al.* In pernicious anemia, the incidence was 8 per cent. Of the 73 cases in the series mentioned, 36 had a single polyp and 37 had more than one. Where symptoms were present, the complaints were bleeding, pain, or vague epigastric distress. The frequency of malignant degeneration has been quoted from 0 to 51 per cent.

Various authors have attempted to list criteria of malignancy. Hay[4] suggests a diagnosis of malignancy when the polyp is more than 2 centimeters in diameter or when x-ray study suggests invasiveness. In the series analyzed by Yarnis,[3] tumors under one centimeter in diameter which are single and which have a benign appearance on gastroscopic and x-ray study, may be considered benign and may be followed periodically. On the other hand, Marshall[5] believes it is impossible to distinguish benign from malignant growths by any method other than direct surgical exploration with biopsy study. In practice, it would seem best to consider all gastric polyps as potentially malignant and justifying serious consideration for surgery. In the case of the solitary polyp which is less than one centimeter in diameter and which has a benign appearance on x-ray and gastroscopic study, surgery can be deferred if the patient will submit to frequent and thorough re-examination. However, the patient who has multiple polyps, achlorhydria, bleeding, and suspicious appearance on gastroscopy or roentgen study, should be sent to surgery without question. Treatment will depend on the findings at laparotomy and will be either simple removal or gastric resection.

Helwig and Ranier[6] discuss another type of gastric polyp which is not truly neoplastic in origin but probably allergic or inflammatory. They have given the name "inflammatory, fibroid polyp of the stomach" to this lesion, which was formerly called benign, eosinophilic granuloma. These usually occur in the antrum and are considered inflammatory. On section, they show fibrous tissue and blood vessels in a distinctive arrangement, with an infiltrate dominated by eosinophiles. Clinically, they cannot be distinguished preoperatively from true neoplastic polyps. They do not become malignant, so that treatment consists in simple excision after the diagnosis has been established.

GALL BLADDER AND DUODENUM

THE gall bladder may be the site of polyps or papilloma, which are usually incidental findings on x-ray study. Ochsner[7] found 10 polyps in the gall bladder out of 1,103 surgical specimens. The Mayos reported 1 per cent in excised gall bladders; and the Lahey Clinic, 4 papillomas and 3 adenomas out of 4,553 specimens. The relationship to carcinoma is controversial. Halpert[8] feels that none of these lesions become malignant while others say that an unknown number will be transformed into gall bladder cancer. Ochsner[7] recommends removal of all gall bladders containing polyps.

In the duodenum, benign tumors were found in 13 of 56,500 autopsies reported by Raiford.[9] These were of the following types: adenoma, myoma, pancreatic rests, lipoma, hypertrophied Brunner's glands, hemangiomas, and others. They may also be found in association with multiple polyps in the remainder of the small intestine, in the Peutz-Jegher's syndrome. These tumors may cause no symptoms or may produce bleeding, pain, or obstruction. Hoffman[10] found 4 malignant tumors of a total of 18 tumors in 64,300 surgical specimens and 4,480 autopsies. Ebert[11] reported 23 primary tumors of the duodenum at the Boston City Hospital in 50 years. Eight of these were benign and 15 were malignant. Polyps of the duodenum require surgery; either simple excision or radical resection, dependent on the findings.

SMALL INTESTINE

THERE has been considerable interest in the study of polyps of the small intestine following the description by Jeghers of the condition which is now called the Peutz-Jeghers syndrome. This is characterized by pigmenta-

tion of the mouth and digits, polyps in the small intestine and other parts of the gastrointestinal tract, and a history of involvement of other members of the family. In 1896, Hutchinson [19] first described the unusual pigmentation of the lips and the buccal mucosa, which is also found on the fingers and toes. In 1921, Peutz [20] noted the association of this pigmentation with small intestine polyposis and hereditary influence. In 1949, Jeghers [12] published his excellent review of the problem, in which he stressed the clinical characteristics previously mentioned. Since this publication, clinicians have been alerted to the problem and have looked for polyps whenever the characteristic pigmentation was noted. These polyps may be found in any part of the gastrointestinal tract, but the small intestine is usually involved.

On histologic examination, these are true adenomatous polyps. They may be asymptomatic or may cause pain, intussusception, or bleeding. Malignant changes have been reported in about 25 per cent in series by Berkowitz [13] and by Vary.[14] Since cancer cannot be diagnosed clinically, treatment must be surgical. The surgery will be simple resection or radical removal, dependent on the findings.

Other types of small bowel tumors may be found in the absence of pigmentation. Olsen,[15] studied the surgical pathology from 1911 to 1942, and discovered 77 tumors, of which 38 had produced symptoms and the remainder were found coincidentally. They were adenomas, leiomyomas, fibromas, lipomas, or pancreatic rests.

LARGE INTESTINE

Polyps take on their greatest importance in the large intestine. The incidence has been reported as 1½ to 12 per cent of the total population. Portes,[16] working in a cancer detection clinic, found that 8 per cent of 50,000 subjects had polyps, discovered by routine sigmoidoscopy. Ninety per cent of colonic polyps can be visualized by the sigmoidoscope. Histologic study shows that these are primarily polypoid adenomas and much less frequently, villous papillomas

In polypoid adenomas, the basic cell type is found at the base of the normal colonic glands. They may be sessile or on a stalk of varying length. They occur as single or multiple tumors. The evidence of malignant degeneration is indirect and disputed by some, but most clinicians believe that a polypoid adenoma of the colon may undergo malignant degeneration, invade the colon, and metastasize. Cancer cells may appear at the tip of the tumor and remain localized there or they may invade the stalk. If one polyp has been discovered, careful search must be made throughout the bowel by air contrast study for other tumors. Deddisch [17] has demonstrated that 50 per cent of polyps beyond the sigmoid could be missed by radiography and were found by him at surgery by colotomy and coloscopy through multiple incisions. Once a polyp has been removed, the patient should be re-examined periodically, because of the tendency of new polyps to form.

The villous papilloma is a less common type, occurring much less frequently than the polypoid adenoma. The basic cell type is the epithelial cell and the cells are arranged in frondlike villiform projections. They are usually soft, sessile growths, found most commonly in the rectum and sigmoid. They occur more commonly in elderly people. They are slow growing and have the tendency to pass large amounts of mucus and fragments of tumor tissue. They may have multiple foci of carcinomatous degeneration. Of a series of 28 cases reported by Bacon,[18] only 2 metastasized. After resection, they are likely to recur.

All polyps of the colon should be removed. The method of removal is a problem for the proctologist or general surgeon.

Familial polyposis of the large intestine is much less common than the types previously described. This is a condition where multiple polyps appear throughout the large intestine at any age, with a definite history of hereditary influence. All these polyps may eventually become malignant, so that they must be removed. The general practice is to do a subtotal colectomy and ileo-sigmoidostomy, with local

removal of the polyps by fulguration. However, some think a total colectomy is the procedure of choice.

SUMMARY

1. Polyps may appear anywhere in the gastrointestinal tract, as simple tumors or multiple growths.

2. A significant number may be asymptomatic; or may occur with bleeding, pain, digestive disturbance, or even obstruction and intussusception.

3. The major problem is the incidence of malignant degeneration which varies with the site and the physiologic state.

4. A syndrome of polyposis, primarily of the small intestine, in association with pigmentation and a hereditary tendency has recently been described in great detail and is known as the Peutz-Jeghers syndrome.

5. There is a strong hereditary tendency to form polyps, particularly in the condition known as familial polyposis of the large intestine and in the Peutz-Jeghers syndrome.

6. Treatment is essentially surgical removal, the technic depending on the type and location.

7. The concern of the internist or general practitioner is to be aware of the situation, to do a routine sigmoidoscopy on all patients past 40 years of age, and to investigate carefully by x-ray study all patients with obscure bleeding symptoms.

299 Clinton Avenue

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DISCUSSION

1. Gelber, M.D., Elizabeth, N. J.: I would like to confine my remarks to the management of diffuse, extensive involvement of the entire colon, including the recto-sigmoid and cases in which the distal segment is free of the disease. I am prompted to do this because of the sharp difference of opinion encountered in three of the four cases which I am about to present:

Case 1—A 28-year old woman underwent subtotal colectomy in August, 1953. The resected colon presented numerous adenomatous polyps with two carcinomas *in situ*. Sigmoidoscopy revealed between 90 pedunculated and sessile polyps. The first team, including a gastroenterologist, proctologist and surgeon, proposed an immediate total colectomy in one or two stages. However, the patient selected

the method of treatment offered by a subsequent team, *i.e.*, that of subtotal colectomy and fulguration of the distal segment for future internal anastomosis. From August to December of 1955, fulguration procedures were carried out. At the end of that time a large carcinoma was found protruding from the proximal end of the stoma. The abdomino-perineal resection was therefore accomplished with establishment of a permanent ileostomy. I have a photograph of this completely rehabilitated patient after four years.

Case 2—A 32-year old man had a total colectomy in two stages. The subtotal colectomy showed 273 polyps and the distal segment showed 50 polyps. His sister in a western city is now undergoing the other method of treatment, *i.e.*, that of a subtotal colectomy with fulguration of the distal segment. Our information is that she had about 50 polyps in the resected colon and an almost equal number is now being fulgurated for future anastomosis.

Case 3—A 54-year old man in May 1955 had a right hemi-colectomy for a large polypoid carcinoma at the hepatic flexure demonstrated by x-ray. The resected specimen showed numerous additional polypi in ascending and proximal transverse colon. A postoperative six weeks' roentgen study demonstrated three additional polypi in the descending colon. Team One advocated a further subtotal colectomy with ileo-sigmoidostomy because on repeat sigmoidoscopic examinations, the distal segment was entirely free of the disease. However, because of difference of opinion between the teams, the operation was not carried out until one year later. By that time, hopeless metastases throughout the abdomen were found and the patient died three months after the second operation.

Case 4—A 24-year old man has had the disease for over five years with extensive involvement of the colon except the recto-sigmoid. He has now remained under observation for three years with re-check sigmoidoscopies which still show a normal recto-sigmoid, and a subtotal colectomy with an ileo-sigmoidostomy are proposed.

In our area, we have an ileostomy club comprised of 60 men and women who have had total colectomies. They have become well adjusted to their ileostomies and are leading useful lives. I would conclude that total colectomy with permanent ileostomy in extensive polyposis is the treatment of choice. This is true also in cases of rectosigmoid involvement.

Rice Diet and Ulcers

Peptic ulcers are "extremely common" in India, especially among the poorer, working classes, a surgeon from that country reported to the International College of Surgeons in 1956. A heavy rice diet, due to economic conditions, may be a contributing factor in this high incidence, according to Dr. K. G. Pandalai of Madras, president of the Indian Section of the International College of Surgeons.

"The main article of diet among these people is boiled rice eaten with curries made of vegetables and seasoned with spices. They consume large quantities at each meal but meat, fish and eggs are eaten very rarely as they are too expensive for the common man.

"This diet is tasty but irritating to the stomach and deficient in fats, proteins and vitamins. In the northern part of India, where a wheat diet is preferred and rice forms only a small proportion of the diet, peptic ulcers occur much less frequently."

Dr. Pandalai made an anlysis of 2,500 patients at a Madras hospital. Only 5 per cent came from the middle and upper strata of society. Only a small number belonged to the business and professional classes. The proportion of males to females was 20 to 1. Ninety per cent of the patients were in the third and fourth decades of life.

Patients usually reach the hospital in late stages when the outlook is desperate, Dr. Pandalai said. The result is a high mortality rate.

"Malignant diseases of the stomach are frequently seen, but over 90 per cent of the cases come too late for removal of the growth or for help of any kind," he reported.

Improvement in economic conditions and habits of life are hoped for to reduce the high incidence of peptic ulcer during the active years of the lives of workers, he said.

Irving Willner, M.D.*

Newark

Modern Problems in Tuberculosis Control

The tuberculosis honeymoon is over. Mortality rates and morbidity rates had been tumbling dramatically with the introduction of modern chemotherapy. But the curve is beginning to turn up again. Some sensible suggestions for control are detailed here.

Control of tuberculosis by modern methods is still far from satisfactory. Morbidity and mortality rates have fallen as a result of advanced medical and surgical procedures. The search for unknown cases and the supervision of spreaders of disease must continue to reduce these rates to a minimum. The problem is an ever changing one in the community.

The introduction of modern drug therapy in tuberculosis required changes in the public health program. Without discarding the time tested methods the entire program was altered. The old regime of collapse therapy is now rarely used. Chemotherapy resulted in fewer cases being admitted to the sanatoria and in a shorter stay in the institution. Some sanatoria no longer have a waiting list for admission and in many there are empty beds. The family physician (not the specialist in chest diseases) assumed responsibility for the care and supervison of the majority of patients. As a result, there was an increase in the number of ambulatory cases. Streptomycin, PAS and INH so simplified therapy that many physicians who never treated tuberculosis because of pneumothorax management now do so. The unhospitalized patient regardless of an active open lesion is often permitted to follow his usual activity.

Marked strides in treatment have resulted in a spurious feeling of security and in false conclusions. The sharp drop in the death rate is not paralleled by the case rate. Mortality statistics demonstrate a steady decline for over a half century. The introduction of anti-microbial therapy precipitated the sharpest drop in medical history. This continued until 1954 in Newark when the decline fell to 68 deaths and a rate of 15.3 per hundred. In 1955, the same ratio resulted, but in 1956 there was an increase to 72 deaths with a rate of 16.3 per hundred. Chemotherapy has not been controlling all patients. In some infected with drug resistant bacilli, the new drugs have been of little or no value. In others, patients whose cases were controlled for some time, have reactivated and died. Morbidity rates have declined gradually but to a markedly less degree than the mortality. The falling death and case rates may lead to the false assumption that tuberculosis is no longer a major problem.

Tuberculosis once a disease of children and young adults is now a disease of older people, chiefly men. As a result of scientific progress, a greater portion of the population now consists of older people and this will continue. Active disease among the old may result from a new infection but in most it is due to an exacerbation of an arrested lesion that may have occurred many years ago, even in childhood. Many debilitating conditions and chronic

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diseases (especially diabetes) in advanced age, can activate or aggravate an underlying tuberculosis. Surveys have proved that some individuals, long treated for "asthma" or "chronic bronchitis" were cases of pulmonary tuberculosis.

Case finding programs consist largely of mass x-ray surveys (among the general population and in industry) and of tuberculin testing in children under 15 years of age. Positive tuberculin reactors are x-rayed as well as members of their families and other contacts to try to locate the source of infection.

Mass x-ray surveys have been conducted for many years. They are preceded by an intensive educational and publicity campaign. These surveys have value in stimulating interest in tuberculosis, locating some active cases, a good proportion of arrested patients, and finding other pulmonary and cardiac abnormalities. The number of active cases located, not previously known to the Health Department, is small, usually less than one in a thousand x-rayed.

The tuberculin test is not only a much more economic method of case finding, but is also the best tool for determining the absence or presence of infection. This method has been limited to children for the most part, but can be used in controlled groups of adults (foodhandlers, school teachers, domestics, employees in industrial plants). Positive reactors are the potentially active cases, and must be followed and x-rayed for several years. Tuberculin surveys among children over many years have demonstrated a remarkable decline in the number of positive reactors. In Newark, clinical records show that the percentage of positive reactors fell from 47 in 1935 to 6 in 1955 and to 4.7 in 1956.

Ambulatory patients are often difficult to keep under rigid control. These are persons with active disease who are usually not isolated. Most of them are known to health authorities, but a good proportion are never known or recognized until just before or after death. Many will not observe precautions to prevent spread of disease.

The category of "unhospitalized known patients" consists of:

1. Patients refusing to go to the sanatorium because of their own reasons; or their physician's refusal to send them.
2. Patients who have "signed out of" institutions.
3. Reactivated patients who have previously been in a hospital, and refuse to return.
4. Patients awaiting admission to a sanatorium.
5. "Good chronics" with lingering tuberculosis and positive sputum who are often allowed to go about their usual activity, and in the meantime spread the disease.
6. Patients discharged from institutions after a short, intensive course of chemotherapy, who are to continue treatment by private physicians or in clinics, who are not arrested and have positive sputa at times.
7. Persons with positive sputa sent to the sanatorium who are discharged because of infraction of regulations even though they are still active and infectious (often drunks and derelicts).

Reasons given by patients refusing to go to a hospital are numerous and include:

1. Not sick enough to go away.
2. Told by their private physician they can get well without hospitalization.
3. Do not believe the diagnosis and cannot be convinced even when x-rays are explained, and positive sputa reports shown.
4. Feel they can get well at home.
5. Fear of institutions.
6. Say they will get better care at home.
7. Religious grounds; feel that they cannot have "disease."

Ambulatory chemotherapy is no substitute for hospitalization of a sputum-positive patient. Unknown cases are those that are never located by health authorities in their lifetime regardless of all case finding methods. They are more dangerous than the known cases as they cannot be supervised or even advised against spread of infection. They are never known until just before or after death. For many years as high as 20 to 40 per cent of all tuberculosis deaths were never known to us before their demise. In 1956, mortality statistics reveal that 39 per cent died without any supervision or control.

Uncooperative known cases contribute to the annual crop of new patients. These individuals with infectious tuberculosis are unwilling to accept treatment or isolation. New Jersey laws state that when a person fails to obey regulations and is a menace to the community, he can be committed to the county

sanatorium. Proof must be presented by a health officer to a judge of the superior court, who then signs the commitment papers. The patient then has to remain hospitalized until he is no longer a menace. He is then released by a court order. Recalcitrants will respond only to forcible legal restriction. Regardless of commitment procedures some do 'walk out" of the sanatorium. From Newark, 43 uncontrollable spreaders have been committed. Of this number, six "walked out." One later returned voluntarily, two were brought back through the efforts of the sheriff, and three are still at large and have not been located. There is no tuberculosis ward in a penal institution where they can be isolated until lesions are arrested. Recalcitrant patients who voluntarily refuse isolation and therapy should be confined during their infectious condition in a state-supported institution.

X-raying of all admissions to general hospitals has been sadly neglected. The rate of tuberculosis found among hospital patients has been estimated to be eight times the rate found on mass surveys. New patients may have no symptoms of pulmonary disease. Locating active disease protects other patients as well as hospital personnel. The diagnosis and isolation of every infectious case is essential and should be a regular procedure. Every hospital employee should have a pre-employment and annual chest examination. This should include members of the attending and house staffs. Here are examples of personnel infected from three different general hospitals in New Jersey.

A 23-year old student nurse had a negative pre-employment x-ray. She worked on medical, surgical, urologic and orthopedic wards. Four subsequent x-ray plates of the chest disclosed no pulmonary pathology. A subsequent x-ray (22 months after employment) revealed a tuberculous process with an infiltrate in the right upper lobe. She was sent to the New Jersey State Sanatorium.

A 45-year old orderly and practical nurse had a negative pre-employment x-ray. One year later he developed a persistent cough. Radiography showed an infiltrate in the second left interspace. He had been taking care of two patients on the medical service who were subsequently diagnosed as active cases of tuberculosis. He was sent to the county sanatorium.

A 22-year old student nurse on pre-employment examination had a normal chest x-ray and a negative tuberculin test. She was assigned to medical and surgical wards. Six months later she complained of weakness and an irritating cough. X-rays revealed a minimal lesion in the left upper lobe. Tuberculin test was now positive. She had taken care of a patient on the medical service who was admitted with a diagnosis of cancer of the larynx. This was later shown to be tuberculous. She was sent to the county sanatorium.

The search for unsuspected pulmonary tuberculosis should be mandatory in all institutions. Men entering the armed forces have been x-rayed on induction and on discharge for many years. This modern screening technic should be followed on all hospital admissions.

SUMMARY

1. Modern chemotherapy has resulted in the general practitioner's treating the majority of tuberculosis patients.

2. Mortality statistics which have declined over the last half century (and markedly since the advent of streptomycin) have levelled off, and are now rising.

3. Morbidity rates are still falling, but less sharply than before.

4. Case finding procedures are largely dependent on mass x-ray surveys and on tuberculin testing programs. Mass surveys have located only a small percentage of new cases. Tuberculin testing surveys, which are more economical, should be intensified and include controlled groups of adults.

5. Ambulatory chemotherapy is no substitute for sanatorium care of an infectious patient.

6. Committed cases should be confined in a state controlled institution until non-infectious.

7. Hospital admission x-rays should be a routine procedure to locate new cases and for the protection of other patients and hospital personnel.

8. Search for unknown tuberculosis and supervision of "spreaders" of disease must be continued and intensified to reduce mortality and morbidity rates.

18 Waverly Avenue

REGINALD F. SEIDEL, M.D.

Englewood

The Cattell Tube in Urologic Surgery*

The ingenious Cattell tube provides good temporary drainage of the upper urinary tract. Dr. Seidel explains its usefulness here in the most practical way: he cites actual cases.

THE Cattell tube has a longer horizontal limb than the conventional T-tube and has been used successfully for splinting and for temporary drainage of the upper urinary tract. The urologic situations in which the Cattell tube has been used are:

1. End to end anastomosis of the ureter following surgical injury to the ureter.
2. Splinting and drainage of the ureter following difficult removal of ureteral calculi.
3. Pyeloplasty.
4. Pelvic drainage following pyelolithotomy.
5. Ureteral strictures.

The obvious advantage of a Cattell tube is that both splinting and draining are possible with one single tube. In most cases it is not necessary to use a larger pessar or Foley type pyelostomy or nephrostomy drain. The T-tube is less traumatic and is removed without difficulty if a small V-shaped incision is made at the point opposite the main limb. This tube remains in place without suturing, other than to the skin. It leaves a small opening which spontaneously closes in a short time. The drainage limb is usually brought out through a separate opening in the pelvis or ureter.

When the urinary drainage is viscous or when excessive bleeding is present, a more adequate type of drainage tube should be used. This seemed the only contradiction found in using the Cattell tube in 16 surgical cases.

Ten urologic cases have been selected to illustrate the five possible indications for the Cattell tube in ureteropelvic surgery.

1. A 45-year old woman had a total hysterectomy and salpingo-oophorectomy for cystadenoma. During the difficult mobilization of the left ovary, the surgeon severed the left ureter 8 centimeters above the bladder. The ureter was immediately sutured end-to-end with atraumatic chromic catgut over the distal limb of a T-tube. The tube drained normal amounts of urine and was removed on the 14th postoperative day. There was no drainage from the wound after the removal of the tube and a pyelogram on the following day showed normal kidney and ureter.

2. A 58-year old man was admitted because of hematuria and pain in the left flank. Intravenous urograms showed a small calculus in the lower left ureter with complete obstruction of the left kidney. It was not possible to pass a catheter into the left ureter at cystoscopy and a ureterolithotomy was done. The calculus was imbedded in a chronically infected ureter as it entered the bladder and the ureter was frayed in removing the calculus. The distal limb of a Cattell tube was passed into the bladder and one suture was used partly to approximate the ureter over the tube. The T-tube was removed in 14 days and a urogram showed good continuity with slight hydronephrosis.

3. A 54-year old woman had intermittent right flank pain for five weeks. Urograms showed a right ureteral calculus with partial obstruction. The operation was right ureterolithotomy and a T-tube was used because of stricture and edema of the ureter. The tube was removed on the seventeenth postoperative day and the wound healed rapidly.

*Read May 1, 1957 before the Urology Section at the Atlantic City Annual Meeting of The Medical Society of New Jersey

4. A 40-year old electrician was relatively asymptomatic but had a lower left ureteral calculus with hydronephrosis and hydro-ureter. At ureterolithotomy an intramural stricture was found. The stricture was incised without doing a ureteroneo-cystostomy. The ureter was left open about the distal end of a T-tube which was removed in 18 days. The postoperative films showed good function but little change in the long standing hydronephrosis and hydro-ureter. The patient has done well since the operation and after running pyuria for six weeks has had clear urine.

5. A 65-year old housewife had persistent pain in the right flank. X-rays showed a left hydronephrosis with calculi and a right ureteral calculus obstructing the kidney. A right ureterolithotomy with T-tube drainage was performed first and 1500 cubic centimeters of urine were obtained from the ureteral incision. Three weeks later a left pyelolithotomy was done but because of the many calculi present and the turbid urine, it seemed advisable to use a pessar pyelostomy on this side. Postoperative urograms six weeks later showed bilateral function but return of calculi in the left kidney.

6. A 42-year old physicist entered the Englewood Hospital with severe right flank pain and high fever. A large pyonephrosis was diagnosed and when the infection had subsided a pyeloplasty was performed. The redundant pelvis was excised and a Foley type Y plasty was used. A Cattell tube was used for splinting the uretero-pelvic junction and for drainage. The postoperative course was uneventful and the tube remained in place for 18 days.

7. A 60-year old tug boat captain had right upper quadrant pain. After considering the possibility of cholecystitis, a right hydronephrosis was diagnosed and an intrinsic ureteral stricture, at the pelvic junction, was incised. The uretero-pelvic junction and upper ureter were splinted by a T-tube after excision of the excess pelvic wall. The tube remained 16 days and the wound drained urine for 3 days more. A follow-up pyelogram has not been taken but the postoperative course is good.

8. A 55-year old executive had a left pyelolithotomy twenty years previous to his present admission for right flank pain and fever. Intravenous urograms showed bilateral hydronephrosis and bilateral renal calculi. It was not possible to catheterize either ureter because of distortion from a previous bilateral ureteral meatotomy. It is interesting to note that the ureters visualize only on the postero-anterior film. This technic is used routinely at the Englewood Hospital on the 12 minute film.

A right pyelolithotomy and pyeloplasty were done with T-tube splinting and drainage. After the tube was removed on the fifteenth day the patient developed high fever uncontrolled by antibiotics. A pyelogram at this time showed the left renal calculus to be blocking the ureter. The foot of the bed was elevated and the kidney unblocked with return of normal temperature. Because of extreme anxiety reaction, the patient was sent home and re-admitted four weeks later for a left pyelolithotomy.

9. A 57-year old carpenter had a history of repeated urinary infections and peptic ulcer for which a gastrectomy was done. Bilateral ureteropelvic obstruction and left renal calculi were diagnosed and at operation a pyelolithotomy with lysis of ureteral adhesions was performed. A Cattell tube was used for drainage and performed well postoperatively. The patient did not return for follow-up films or possible revision of the right kidney pelvis but telephoned me and stated he was doing well.

10. This 34-year old window washer was treated for six months for a "nervous stomach." He had gross hematuria for two weeks and was admitted to the Englewood Hospital. A large left renal calculus was found on x-ray and a pyelolithotomy was done. There was a completely intra-renal pelvis. The ureter was damaged at its upper end so that only a narrow band held it to the kidney. The ureter was left open over a Cattell tube which was brought out through the normal ureter three centimeters below the kidney. The tube remained 20 days and the wound was dry two days later. The postoperative course has been good and the patient doing his normal work three weeks after discharge from the hospital.

240 East Palisade Avenue

Details of the Cattell tube may be found in Dr. Cattell's paper in the January 1946 issue of the Bulletin of the Lahey Clinic, 4:197.

Historical Article • • •

FRED B. ROGERS, M.D.*

Trenton

The Last Illness of Robert McKean (1732-1767)

For want of fifty cents' worth of isoniazid and for lack of a small supply of para-aminosalicylic acid, the career of Robert McKean was cut short at the age of 35. Events like this spotlight the real meaning of advances in medical science.

RECENT discovery of a letter, written in the year 1767, directs attention to the last illness of the Rev. Dr. Robert McKean, first President of The Medical Society of New Jersey. This letter, a reply by Dr. John Morgan of Philadelphia to Robert McKean in New Jersey, was copied by Jonathan Elmer while serving as an apprentice to Dr. Morgan. Dr. Morgan was the founder of this country's first medical college—now the University of Pennsylvania School of Medicine.

Robert McKean, a Pennsylvania-born missionary from The Society for the Propagation of the Gospel in Foreign Parts to New Jersey, returned from ordination in England to serve as missionary at Christ Church in New Brunswick for six years (1757-1763). In recognition of his signal service as priest and physician, he was awarded an honorary Master of Arts degree by the College of Philadelphia in 1760. During the last four years of his life, Dr. McKean was the rector of St. Peter's Church in Perth Amboy. This church, founded in 1685, is the oldest parish in New Jersey.

While at Perth Amboy, where he served as clergyman, physician and schoolmaster, Robert McKean became a founder and first President of The Medical Society of New Jersey at its organization meeting in New Brunswick on July 23, 1766. He was re-elected President of this Society (the first permanent body of its kind in North America) at its third meeting, on May 5, 1767—four months before his death from pulmonary tuberculosis.



SEAL OF THE SOCIETY FOR THE PROPAGATION OF THE GOSPEL

Figure 1.

*Dr. Rogers is Associate Professor of Preventive Medicine, Temple University School of Medicine, Philadelphia, Pa.

Dr. McKean first reported the sickness which was to destroy him in a letter, dated April 17, 1767, to the Secretary of The Society for the Propagation of the Gospel in London. He wrote that, about the 25th of October, 1765:

"I was seized with a very tedious and dangerous sickness that rendered me entirely incapable of any business for about three months."

Because of this illness, we learn from the recently-discovered letter that McKean consulted Dr. John Morgan of Philadelphia, a distinguished medical graduate of the University of Edinburgh who had returned to establish the first medical school in the American colonies in 1765.

WRITING from Perth Amboy, the clergyman-physician presented his case and sought the counsel of his colleague at Philadelphia. The advice, in Dr. Morgan's reply, was copied by Jonathan Elmer, then Morgan's apprentice, and has survived for almost two centuries in the former's notebooks. Permission to publish the following letter for the first time was granted by its present owner, Mrs. Robert P. Elmer of Wayne, Pennsylvania. Her husband the late Dr. Robert P. Elmer, was a member of the distinguished New Jersey family which has produced so many physicians during the past two hundred years. His ancestor, Dr. Jonathan Elmer (1745-1817) of Bridgeton, N. J., was graduated Bachelor of Medicine in the first medical class at the University of Pennsylvania in 1768, and received his M.D. degree there in 1771. (The latter diploma was recently presented to the University by another descendant, Dr. Walter G. Elmer of Philadelphia.)

Dr. Jonathan Elmer became a member of The Medical Society of New Jersey in 1772. He was elected its fourteenth President in 1787—the year before his election to the U. S. Senate. In addition to medical practice, Jonathan Elmer was active in civic and political life, serving in the Continental Congress, as Judge of the Cumberland County Court, and member of the American Philosophical Society. Referring to Dr. Elmer's medical skill, his contemporary Benjamin Rush said that, "he was exceeded by no physician in the United States."

The following letter, a case report in style worthy of an ethical consultation today, was copied as a model, perhaps, in Jonathan Elmer's notebook. Its tragic frankness and curious therapeutic advice were obviously products of serious thought on the part of Dr. Morgan.

Case 4th — September 3d, 1767
Phthisis Pulmonalis
Containing
Instructions to Dr. Robt. McKean
By
John Morgan, M.D.

To Dr. Robert McKean

"Last night I received your obliging favour of the 20th Instant. & now set down to answer it with that attention which I think it deserves. Little should I merit that confidence you are pleas'd to repose in me if I was not to deliberate very seriously of your case, or were I to procrastinate giving my advice when asked in a matter of so much consequence.

"My sentiments therefore shall be delivered with that candour & punctuality I should hope for myself in like circumstances.

"The clearness with which you deliver your history of the disease leaves no ambiguity with me as to the nature & extent of it. That your life is in danger if the utmost management is not made use of I apprehend must be your own opinion. For my part I am persuaded that all the attention of your friends & your own will are indispensably necessary for your relief, and under God nothing less can prove effectual to give a happy issue to the disorder.

"I doubt not but every thing that hath been done is right, but as you do not relate what plan of cure you observ'd till you ask'd my advice, I think it proper to write as if it were not a case which has been already under the care of any physician, by which I mean to deliver my opinion as in a consultation of several call'd together, & as the younger giving my advice first.

"That your disorder is a true *phthisis pul-*

monalis appears evident to me, but I think it is not yet so far advanced but that it may admit a radical cure; if we are so happy as to agree upon a proper plan of treatment, which is the thing now to be considered. Let us then take our Indications from the present state of your lungs & strength of body. The fever & pain with the night sweats & difficult respiration, together with the violence & duration of the disease, the troublesome cough & the present ulceration of the Lungs are to give us light in this matter. These declare a very general & hitherto a very fixed obstruction in that viscus. The sweats arise from the absorption of Pus into the Blood, as is plain from the decrease of this symptom since an expectoration came on.

"That these are Tubercles in the Lungs is highly probable from that constant irritation to cough, & from this consideration that inspection has invariably demonstrated the existence of tubercles in every similar complaint so violent & so long continued. The strength of body must be greatly impaired from every concurring circumstance.

"The curative indications therefore, are 1st: To resolve the remaining obstructions, which has now begun to give way. 2d: To palliate urgent symptoms, and 3d: To regard & support the strength of the constitution.

"To answer the first intention was the chief aim of my last letter—Let me enumerate a few of the most powerful pectoral deobstructents. V.S.* has been, & perhaps may yet be reckoned indispensable, but there much skill is requir'd. I apprehend however greater danger arises from a sparing timidity, than from repeating the operation *pro re nata*.† An abatement of pain, and the feel of the pulse can afford a more certain criterion of the sufficiency of bleeding than the apparent texture of the Blood being free from size; tho much depends on this too, as when it happens Blister and attenuant pectorals may sometimes do the rest. Gentle shocks of an emetic now & then *i.e.*, perhaps twice a week, will often carry off obstructions, when V.S.* etc., have been premised & were not sufficient of themselves.

"When I speak of Blister I would mean that a perpetual Blister should be employ'd at least till the pain ceases. By pectoral deobstruents & attenuant pectorals I mean not those that merely sheath as oily & mucilaginous, which to be sure are vary proper in their place when the obstruction is pretty well resolved, but also mediums that attenuate & promote the bronchial secretions, as the decoct. Senechae, Exym: Scillit:, Pill: Scilit: joined with Gum ammon:, Flor: Benzoin:, Sapon: venet: & small doses of Calomel.

"My idea of the operation of the means recommended to resolve an obstruction of the Lungs is this; venesection lessens the compaction or cohesion of obstructing globules. Senecha & Calomel break down the globules into lesser spherules, to be the mode of action what it will. Pills of squills & gum ammon: with soap etc. unite in them the same quality of breaking down those globules with this very necessary one *viz*: of promoting the bronchial functions.

"Emetics pump up what is loosened, but what the others are not sufficient to carry off by the ordinary powers of secretion. Oily medicines merely cover the acrimony of Pus, & perhaps by taking off somewhat from the stimulus it would occasion may relax the vessels & forward expectoration, but Aqua Hordeata, Rad: & succ. Glycirrhiz: G: arabic, etc. do better, with which may be joined a few drops of antimonial wine.

"Rennet whey is cooling & demulcent, also dilutes the blood. Milk requires little labor of the Lungs for sanguification. The juices of the warm antirheuatic plants are proper, as of the Dandelion cresses etc. (if not out of season).

"2d Indication. As to palliatives, the Elixir paregoric is the most effectual with sugar candy & the like to still & quiet the cough.

"3d Indication. When the stricture of the thorax, the pain & difficult respiration are relieved & expectoration pretty free, slight Decoctions or Tinctures of the Bark to begin with, then bitters & Elixir vitrioli may come

*Venesection.

†Better recognized by the modern physician under its abbreviation p.r.n.

in — & lastly Bark in substance, gentle exercise, etc.

"But above all a free & temperate Air is necessary throughout the whole of the disorder, therefore get out as often as you can. — If you or other gentlemen who may be advised in the case approve of the above, it will be easy to improve these hints into proper formula."

JOHN MORGAN, M.D.

COMMENT

MINUTES of the second general meeting of The Medical Society of New Jersey, convened in Elizabeth on November 4, 1766, note that, "the President was prevented by sickness from giving his attendance." Dr. McKean sent a letter, however, for discussion by the members present at this gathering. At the third meeting, held at Perth Amboy on May 5, 1767, McKean presided and was re-elected President, a token of the esteem in which he was held by his medical colleagues.

Despite heroic treatment, McKean's tuberculosis progressed steadily. On October 12, 1767, the Rev. Thomas Chandler of St. John's Church, Elizabeth, notified the Secretary of the Society for the Propagation of the Gospel in London that his fellow missionary was dying:

"Wasted away with a tedious disorder, the worthy, the eminently useful and amiable Dr. McKean is judged by his physicians to be at present at the point of death."

Five days later, on October 17, 1767, McKean died at his father-in-law's home, Ross Hall, at Raritan Landing near New Brunswick. Dr. McKean was buried in the churchyard of his parish at Perth Amboy, where one can read his epitaph today.



Figure 2.

In appreciation of his pioneer service, The Medical Society of New Jersey erected a tablet in St. Peter's Episcopal Church at Perth Amboy in 1923—on the 225th anniversary of this historic parish. This tablet, bearing the seals of The Society for the Propagation of the Gospel and The Medical Society of New Jersey, records a memorial inscription to Robert McKean. It is located on the west wall of the church where this pastor-physician served and where his remains now rest.

2200 Hamilton Avenue

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2. Eagleton, W. P.: Memorial to the late Robert McKean, Journal of The Medical Society of New Jersey, 20:45 (Dec. 1923).

3. Rogers, F. B.: Robert McKean, First President of The Medical Society of New Jersey, Journal of The Medical Society of New Jersey, 50:432 (Sept. 1953).

State Activities • • •

Trustees' Meeting: September 15, 1957

At its session on September 15, 1957, the Trustees voted to:

—Co-sponsor the Fifth Annual Cancer Seminar in Atlantic City in November.

—Authorized separate grouping of osteopaths in Medical-Surgical Plan's roster of physicians.

—Named Dr. Irving Klompus as liaison representative to the New Jersey Welfare Council.

—Named Dr. George Ginsberg as representative on the Diabetes Detection Drive.

—Authorized Dr. Neil Castaldo to attend the National Conference on Physicians and Schools.

—Authorized Dr. Frederick Erskine to attend the A.M.A. Conference on Mental Health.

—Authorized Dr. John Huston, III, to attend the A.M.A. Public Relations Institute.

—Declined to name representatives to the Symposium on Nutrition in Pregnancy (to be held in Missouri), the National Conference on Citizenship (Washington, D. C.) or the Rural Health Conference (to be held in Indiana).

—Established an *ad hoc* committee on Asian Influenza with power to make decisions and approved the composition of that committee as follows: Doctors F. C. Bowers, R. S. Garber, J. F. Kustrup, Carl N. Ware, and Albert B. Kump.

—Endorsed the influenza vaccine priorities developed by our State Department of Health. (See page 545 this Journal)

—Approved, disapproved or modified various components of the July 14 session of our Welfare Committee. See below.

—Established a special committee on Traffic Safety consisting of Doctors A. M. K. Maldeis, S. E. Dalton, H. F. English, R. S. Garber, and J. F. Kustrup.

—Authorized wider publication of the availability of the Medical Student Loan Fund and advised that pharmaceutical houses and other outside sources should not be solicited for contributions.

—Accepted the report of the Auditors, and of the Audit Committee.

—Authorized officials of our Society to meet with representatives of the State Commissioner of Labor and of the Workmen's Compensation Bureau to develop procedures for studying medical testimony.

—Adopted the principle of reimbursing for the President's expenses at the Annual Meeting with the understanding that the expenses of other officers would not be paid from Society funds.

—Adopted a schedule for reimbursement of the expenses of guest speakers at our Annual Meeting.

—Adopted a schedule for reimbursement of the expenses of our representatives to various official functions.

—Endorsed the nomination of James H. Spencer, M.D., Duane E. Minard, Jr. and Robert G. Boyd to the Board of Medical-Surgial Plan.

—Granted a request from the Seton Hall College of Medicine and Dentistry to have envelopes addressed to the membership through the Society's office machinery for the mailing of a communication asking for the names of possible contributors to that College's fund drive. It is understood that this is not a solicitation of the members, merely a request for their help in making up a list of potential contributors.

Welfare Committee: July 14, 1957

The following Welfare Committee recommendations (based on the July 14 session) were approved by the Board of Trustees on September 15, 1957.

1. Space in the JOURNAL to be alloted regularly for articles on the diagnosis and treatment of cancer, to be prepared by the Committee on Cancer Control.

2. In cooperation with the American Cancer Society, a roster of cancer films will be compiled.

3. There will be distributed to hospitals a re-

port on maternal and infant mortality and on the classifications and definitions of neonatal, prenatal and perinatal births.

4. A new questionnaire will be developed in conjunction with the State Health Department for use of Field Physicians in exploring maternal deaths.

5. Approved of legislative bills A-207, and S-254.

6. Disapproved of legislative bills A-390, A-498 and S-88.

7. Endorsed the agenda of the Committee on Medical Practice in which were included a fee schedule study project, a disability survey, and a clarification of the definitions of ophthalmologist, oculist, optician and optometrist.

8. Approved a number of on-going public relations projects.

9. Recommended participation in the Station WTTM project, "Labor Talks it Over."

10. Assisted in making available the film "Monganga" dealing with medical missionary activities.

Influenza Vaccine Priorities

The Medical Society of New Jersey calls upon its members to make full utilization of all vaccine as it becomes available for the benefit of the public. It relies with confidence upon its component county medical societies to work out details for the local administration of the program in accordance with local situations.

The Medical Society of New Jersey concurs in the policy statements issued by the American Medical Association and the United States Public Health Service and recommends them to the attention of its members.

The Medical Society of New Jersey recognizes the vaccine as the most effective form of immunization presently available against Asian Influenza.

At the present time, in view of the scarcity of the recommended vaccine, it would seem desirable, even necessary, to set up priorities for the administration of the vaccine. For the guidance of its members in the component county medical societies, The Medical Society of New Jersey offers the following order of priorities, prepared and released by the New Jersey State Department of Health:

1. Staff and employees of hospitals.
2. Employees of agencies and professional individuals providing direct health, pharmaceutical, and religious services to sick persons.
3. Personnel necessary for the operation of governmental services and public utility services essential for the health and safety of the population. These should be limited to law enforcement, fire protection, health protection, water supply, sewage disposal, and power and light distribution services.
4. Seriously ill persons, the very old, pregnant women, and children under one year of age who in the judgment of their physicians are a special risk.
5. Essential personnel operating all other public utilities not covered under number 3.
6. All others persons.

The Medical Society of New Jersey concurs in the recommendation that the vaccine be administered to the patient by his own physician because of individual allergies and resultant possible reactions to the vaccine.

The Medical Society of New Jersey recommends the continuance of the established policy of the State Department of Health which makes available, through its local biological distribution stations, vaccine purchased from tax funds for administration by physicians to the indigent.

The Medical Society of New Jersey emphasizes to the membership that if the foregoing priorities are locally adopted it is absolutely necessary that they be adhered to.

As a further means of insuring the efficient efforts of organized medicine in New Jersey, The Medical Society of New Jersey has established a special *ad hoc* committee which will meet from time to time to deal with the various phases of the Asian Flu situation. It will be the responsibility of this special committee to keep in touch with developments at county levels, to recommend modifications of policy as necessary, and to keep component county medical societies informed.

—Adopted by the Board of Trustees of The Medical Society of New Jersey, September 15, 1957.

Obituaries • • •

DR. GEORGE F. BROWNE

While visiting in Connecticut over the Labor Day weekend, Dr. George Francis Browne died suddenly at the age of 46. A graduate of the Hahnemann Medical College, class of 1939, Dr. Browne was a well known Essex County anesthesiologist. He was attending anesthesiologist at the Mountainside Hospital in Glen Ridge, and active in both the American Society of Anesthesiologists and its New Jersey affiliate. He was a diplomate of the American Board of Anesthesiology.

DR. GEORGE A. CORIO

One of Mercer County's best known otolaryngologists, Dr. George A. Corio, died September 28. Born in New York in 1899, he was graduated in 1924 from Georgetown University Medical School. Dr. Corio came to Mercer County to intern at the St. Francis Hospital, and elected to make his permanent home in Trenton. He became increasingly interested in otology and laryngology and over the years advanced in St. Francis Hospital from clinical assistant to chief of service in that specialty. Dr. Corio was also active in civic affairs. He served for a decade as Trenton City Physician. He was a medical consultant to the State Athletic Commission and was also a consultant to the prosecutor's office. He served his county medical society in all capacities including that of president. He was the county's nominating committee delegate to The Medical Society of New Jersey. He was on the Board of Directors of a local Building and Loan Association, and active in American Legion and Elks affairs. Dr. Corio had been a major in the National Guard and was, for many years, sergeant-at-arms of the House of Delegates of The Medical Society of New Jersey.

DR. CHRISTIAN H. MERSHEIMER

After having served the people of Hudson County for over half a century, Dr. Christian H. Mersheimer died of a heart ailment on September 25. Dr. Mersheimer was born in New York in 1874. He was graduated in 1902 from the New York Medical College and interned at the Flower Hospital. The following year he crossed the Hudson and entered general practice in the Jersey City area. He was associate physician on the staff of Christ Hospital in Jersey City and engaged in active old-fashioned family practice until his retirement several years ago.

DR. AUGUST W. MOSER

While on vacation in Innsbruck, Austria, Dr. August Moser of Englewood, New Jersey, died of pneumonia. Dr. Moser was born in Bavaria in 1914 and came to this country as a child. He was graduated in 1949 at the Medical School of New York University. He did general practice at first but became increasingly interested in pediatrics. He was a member of the pediatric service at St. Vincent's Hospital in New York and was an associate pediatrician at the Englewood Hospital in New Jersey. Death occurred on September 10.

DR. BAXTER TIMBERLAKE

Dr. Timberlake, last year's president of the Atlantic County Medical Society was born in 1900 at Luisburg, N. C. He had a distinguished career both in civilian and military medicine. He was a chief of ear, nose and throat at Atlantic City, Shore Memorial, Fish Memorial Hospitals, and the Children's Seashore House. He received his M.D. degree at the Jefferson Medical College of Philadelphia in 1928.

After interning at Atlantic City Hospital where he also served as Resident Physician, Dr. Timberlake opened an office in Atlantic City in 1930. He practiced general medicine five years then became interested in otology and laryngology. During the next two years he studied at the University of Vienna and other European medical centers.

During World War II, Dr. Timberlake was commissioned a major in the Army Air Force Medical Corps and served throughout the war. He took part in seven bombing missions while attached to the 15th Air Force, based in the Balkans. After VE-Day, he was transferred to Brazil to serve with American forces there. One of his patients was General Mark Clark.

He was separated from the service in 1945 with the rank of Lieutenant Colonel.

Dr. Timberlake was Vice-President of the New Jersey Academy of Ophthalmology and Otolaryngology and a member of the State Medical Society's House of Delegates for many years.

His other professional affiliations include certification by the American Board of Otolaryngology and Fellowships in the International College of Surgeons, Tri-Ological Society and the American Academy of Ophthalmology and Otolaryngology. He belonged to Ventnor Community Church, the Seaview Country Club and Atlantic City Country Club.

On September 26, 1957, Dr. Timberlake died in the line of duty. On that dark night, he was called to a hospital to check a post-operative nose bleed. After accomplishing his mission he left to return home, and missing a sharp curve his car crashed through a guard rail into Risley's Channel. In the fall, Dr. Timberlake suffered a fractured skull, and was then drowned in the car in which he was trapped.

Announcements • • •

Psychiatry and Public Health

On Wednesday evening, November 20, Dr. Paul V. Lemkau of Johns Hopkins will speak on the role of psychiatry in public health. This session, which begins at 8:45 p.m., will be held on the third floor of the Veterans Administration Hospital in East Orange. This is the C. C. Beling Memorial Lecture of the New Jersey Neuropsychiatric Association. It is co-sponsored by the Psychiatric Service of the Veterans Administration Hospital.

Course in TB Diagnosis

Starting on January 20, 1958, a full-time, 10-day course in laboratory diagnosis of tuberculosis will be given in Atlanta, Georgia. This free-tuition course is open to physicians and technologists. It is sponsored by the United States Public Health Service and details may be obtained from that service at P.O. Box 158, Chamblee, Georgia.

Thyroid Prize

The American Goiter Association again offers the Van Meter Prize Award of $300 and two honorable mentions for the best essays concerning original work on problems related to the thyroid. The award will be made at the annual meeting of the Association in San Francisco, June 17, 1958.

The competing essays may cover either clinical or research investigations, should not exceed 3,000 words in length and must be presented in English. Duplicate typewritten copies, double spaced, should be sent to Dr. John C. McClintock, 149½ Washington Avenue, Albany 10, New York, not later than February 1, 1958.

A place will be reserved on the program of the annual meeting for the presentation of the winning essay by the author.

Seminar on Unusual Tumors

The Annual Slide Seminar on Unusual Tumors, sponsored jointly by the New Jersey Society of Clinical Pathologists and the New Jersey State Department of Health, will be held at 2 p.m. on December 7, 1957 (Saturday) at the Essex House, Newark. Dr. Arthur Purdy Stout of Columbia University will act as moderator. Murray Shulman, M.D., of Irvington General Hospital, is Chairman of the Program Committee. The New Jersey State Department of Health is represented by E. L. Shaffer, Ph.D., Director of Laboratories. All interested physicians are invited to attend.

A Cruising Convention

The Pan American Association of Ophthalmology will hold its second Cruise Congress, February 1 to 14, on board the S. S. *Queen of Bermuda*. The itinerary includes Puerto Rico, Dominican Republic, Jamaica, Haiti, and Nassau.

The program agenda includes symposia, papers, motion pictures, seminars and exhibits stressing subjects of current interest in diseases of the eye. Meetings will be held on shipboard and also in port cities with local societies of ophthalmologists. There will be opportunities to visit hospitals and to meet the staffs of medical schools in the islands.

Mr. Leon V. Arnold, 33 Washington Square West, New York 11, is in charge of arrangements. All reservations must be made through Mr. Arnold.

Radiologic Safety

A two-week, full-time course in Radiologic Safety will be given from January 6 to 17, 1958, by the New York University Graduate Medical School, in cooperation with the NYU College of Engineering and the United States Atomic Energy Commission. It is designed for physicians who are responsible for radiologic safety.

Particular attention will be given to radiation problems in industry associated with radioisotopes and radiation sources including industrial x-ray and power reactors. Covered will be such topics as nuclear physics, the biologic effects of radiation, the principles of radiation protection and governmental codes and regulations. Tuition is $90.

For further information write to the Associate Dean, Graduate Medical School, 550 First Avenue, New York 16, N. Y.

Diabetes Detection Drive

The annual Diabetes Detection Drive will be held in New Jersey November 17 to 23, under joint sponsorship of The Medical Society of New Jersey, the New Jersey Diabetes Association, and the New Jersey State Department of Health. Each of the twenty-one component county medical societies has a diabetes detection and education committee which works in cooperation with local volunteer groups. Major emphasis is on the educational aspects of diabetes control, as well as on an effort to detect unknown cases of diabetes. The local committees will use various technics of diabetes detection, including Dreypaks, enzyme appraisals and blood sugars.

All New Jersey physicians are urged to participate in the Diabetes Detection Week by testing all patients they see as well as any who may request a test.

Communicate with the State Department of Health in Trenton or with your local committee for further information.

County Society Reports • • •

Gloucester

The *Gloucester County Medical Society* was fortunate to have as its speaker at the opening meeting this fall season, Dr. Edward Gosfield, Director of the Hypertension Clinic at University of Pennsylvania. Dr. Gosfield presented a paper on "Hypertension Today" to the Society on September 19, 1947 at the Woodbury Country Club after the President, Dr. James Kehler opened the meeting.

At the business session, a letter was read from the Navy Yard in Philadelphia, requesting approval of a program of immunization against both influenza and poliomyelitis to be given to its employees. The Society voted approval of the program.

Mrs. Marian Chew was introduced and welcomed to her position as executive secretary. A motion was passed that the minutes of each meeting be duplicated and mailed to all members.

ROGER D. LOVELACE, M.D.
Reporter

Salem

Plans for the distribution of Asiatic influenza vaccine were discussed at the first regular meeting of the *Salem County Medical Society*, Friday afternoon, September 20, at the Du Pont-Penns Grove Country Club. Dr. W. Garrett Hume presided and reported on communications received from The Medical Society of New Jersey and from Dr. Lewis L. Coriell of Camden Municipal Hospital stating recommended priorities and dosage schedules for administration of the vaccine. A resolution was passed to fix the maximum fee for influenza vaccination by members of the Society at $5.00.

The Society approved a request from the U. S. Naval Shipyard in Philadelphia for authorization to administer vaccine to civilian employees from Salem County upon request. A communication was received from the New Jersey Health Council suggesting the holding of public meetings to disseminate information about influenza, but the society felt that such meetings would tend to encourage the spread of any contagious disease and resolved to continue distributing information releases through the local newspapers, as in the past.

Dr. Hume reported on two meetings he had attended at Camden Municipal Hospital in July and August and on his presentations to the Salem County Board of Chosen Freeholders at their August and September meetings, all relative to the care of Salem County patients with contagious diseases. The Camden Municipal Hospital, which has been treating such patients, is to be transferred to Camden County ownership later this year and will not be able to admit Salem County patients, Dr. Hume said, unless a fixed sum is appropriated by Salem County to defray the overhead expenses of maintaining and staffing the hospital for contagious-disease patients, regardless of whether any Salem County patients need to be admitted. Delegations from the Board of Freeholders have been invited to tour the hospital with representatives of our Society.

W. L. SPROUT, M.D.
Reporter

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Guide to Medical Writing; a Practical Manual for Physicians, Dentists, Nurses, Pharmacists. By Henry A. Davidson, M.D. Pp. 338, New York, Ronald Press Co., 1957. ($5.00)

This interesting and valuable book provides a *vade mecum* for persons interested in medical writing. It is a practical guide—one for all members of the health team—on the "how" of expressing ideas in readable and understandable fashion. The author, well known to us as Editor of THE JOURNAL of The Medical Society of New Jersey, writes from wide and successful experience in medical journalism. Parts of this book will remind readers of his interesting articles on medical writing published earlier in this JOURNAL.

Not primarily a style book, this practical gulde offers helpful suggestions to the reader on preparing articles for publication. Focusing ideas, organizing material, mastering a readable form and the mechanics of presentation—all aspects of a medical paper — from choosing the title to writing a summary, are covered. Suggestions for research, outlining, revision, use of illustrations, numerical facts and figures, proof-reading, and bibliography are all reviewed in a concise manner. In its 18 chapters and index, this volume offers a readable account of the difficult art of putting ideas into clear and terse prose.

Dr. Davidson, a man who has labored long in the field of medical writing, is the author of several books, and frequent contributor to medical periodical literature. In the Preface to this *Guide* he acknowledges the helpfulness, among others, of Mrs. Miriam N. Armstrong, Assistant Editor of THE JOURNAL of The Medical Socley of New Jersey, and notes "a final word of gratitude to the greatest teachers of all, the authors who sent me their manuscripts. They put up with my crotchets and taught me what to expect from writers and what to do about it." This book is heartily recommended to all interested in successful professional communications.

FRED B. ROGERS, M.D.

Care of the Expectant Mother. By Josephine Barnes, M.D. New York, 1957. Philosophical Library, Pp. 270. ($7.50)

This practical guide is well written and authoritativo. It is a rather expensive book for its small size. It ls especially worth while for the general practltioner and is a useful addition to the obstetrician's library. The book is right to the point and the only item which would not apply in America would be Chapter 6 on Maternity Service in Britain. This chapter is of interest as a sidelight on socialized medicine in Great Britain.

Primarily the book deals with medical obstetrics rather than operative procedures. Surgical procedures are suggested but the details are left to other texts.

The book opens with a review of anatomy, physiology and the details of general and special examinations. A chapter on advice to the mother discusses hygiene, diet, traveling and day-to-day living. Preparations for childbirth are also reviewed including a concise discussion of blood groups and Rh factors. The next section deals with abnormal pregnancies with emphasis on early diagnosis before onset of labor. There is an excellent chapter on hemorrhage in early pregnancies, others on antepartum hemorrhage and toxemias. Also included is a good discussion of the complications of pregnancy. The effects of maternal diseases on the course of pregnancy are discussed, as well as the effects of pregnancy on co-existing disease. On the whole, this is a dependable manual on medical obstetrics.

HERSCHEL S. MURPHY, M.D.

A Manual of Pharmacology. By Torald Sollman, M.D. Pp. 1535. Philadelphia 1957. Saunders. ($20.00)

The wheel of medicine has turned again, and now pharmaceuticals have become fashionable and important. What with steroids and tranquilizers, antibiotics and cholinesterase inhibitors, the practitioner has at his command a warehouse of medications that no king could have bought a few decades ago. But the very complexity of modern pharmaceuticals, and the false simplicity of the manufacturers' brochures and the detail man's patter have all conspired to make pharmacology confusing.

As a guide through this jungle here is the 8th edition of Sollman. For forty years Sollman has been a pharmacological *rade mecum*. This brand new edition will not disappoint the medical public. Some idea of the richness of its scholarship is a listing of more than 10,000 references (that's right, 10,000 not 1000)—and all of them citing papers published since 1940. The book includes material on diet, conversions of weights and measures, pharmaceutical methods, prescription writing and toxicology. The bulk of the text is devoted to a consideration of all the usable drugs of modern medicine. For each there is a monograph on the source, dosage, physiology, administration, fate in body,

contraindications, and effects. The style is a bit on the heavy side—though perhaps the subject is one that cannot be treated in words of one syllable and the book is not recommended for light summer reading. But if you want a solid and authoritative text that tells all you need to know about pharmacology, here it is.

VICTOR HUBERMAN, M.D.

Peripheral Circulation in Health and Disease. By Walter Redisch, M.D. and Francisco F. Tangco, M.D. New York, 1957, Grune and Stratton. Pp. 154 with 25 figures. ($7.75)

The rapidly developing science of angiology makes this slim but compact volume particularly timely. The authors approach the problem in systematic fashion, first considering the anatomy of the vascular tree, then proceeding to review physiology, pathology, clinical evidences of malfunction, differential diagnosis, testing technics, pathologic physiology, and methods of treatment. The book includes a unique supplement written by Dr. R. L. Saunders of Halifax, on the anatomic basis of peripheral circulation. The treatment methods are up-to-the-minute and presented in crisp and usable fashion. This is a book which will appeal alike to the basic scientist and to the clinician. Incidentally, the senior author, Dr. Walter Redisch, has had many years of New Jersey association, having served as chief of medicine, later as consultant at the Veterans Administration Regional Office in Newark.

ULYSSES FRANK, M.D.

Modern Therapy in Neurology. Edited by Francis M. Forster, M.D. With contributions by 21 other physicians. St. Louis, 1957, Mosby. Pp 792. ($12.00)

It is a conventional indictment of the neurologist that he seems enchanted by problems in localization or by hair-splitting differential diagnosis of degenerating diseases; but he seems indifferent to treatment. This was never true — and with this book, we have a monograph focussed squarely on therapy. While there are no specifics offered for multiple sclerosis or dystonia musculorum, the authors do give practical suggestions for the management and comfort of the patient. There is an excellent and usable chapter on head injury, and the book is filled with practical pointers on the treatment of encephalitis, parkinsonism, headache, epilepsy, and even brain tumor. Dr. Fabing contributes an up-to-date (and hopeful) chapter on the use of tranquilizers in neurology. Doctors Bailey and Korengold have a practical chapter on rehabilitation. This is the kind of volume that makes one wonder why no one thought of writing such a book before. It is hard to believe that any one will practice neurology tomorrow without a copy of Forster in his library.

HENRY A. DAVIDSON, M.D.

Benjamin Franklin's Unfinished Business. Edited by Helen and Clarence Jordan. Philadelphia 1957. The Franklin Institute. Price not stated. Pp. 315.

In 1956 there were world-wide celebrations of the 250th anniversary of the birth of Benjamin Franklin. This profusely illustrated volume collects papers by distinguished authors who discuss various facets of Franklin's works. There is a discussion of Franklin and the "Unconquered Fields of Medicine;" Franklin and science; Franklin and sociology; Franklin and literature and so on. On the whole a pleasant potpourri that one can dip into from time to time with considerable enjoyment.

ABRAHAM LEFF, M.D.

Psychosomatic Medicine. By Edward Weiss, M.D. and O. S. English, M.D. Philadelphia, 1957, Saunders. Pp. 557. Ed. 3. ($10.50)

The broad acceptance of psychosomatics has been the medical phenomenon of the postwar decade. To that acceptance, this pioneer volume has contributed a good deal. The book's major value is in its formulation of concepts, and its major weakness is in its failure to give usable treatment suggestions. For instance, to treat the vomiting of pregnancy, the authors advise: "present the problem to the patient as one of resistance to the pregnant state. Explain the mental mechanisms. To regard vomiting in pregnancy as a physical ailment is to fail to do justice to the patient." Or, in a case of epilepsy, the authors "treated the emotional problems of the epileptic and his wife. We did not abolish the seizures, but by combating dependency and tendency to withdrawal we did succeed in reducing the number." The book includes a good treatment of personality development and psychopathology and offers many hints as to psychosomatic history taking. Many jewels of wisdom will be found embedded in the book's numerous platitudes. There is good material on emotional preparation for surgery.

JOSEPH SANTANGELO, M.D.

Psychopathic Personalties. By Harold Palmer, M.D. New York, 1957. The Philosophical Library, Pp. 179. ($4.75)

To American readers, the title of this book is misleading. Dr. Palmer (a distinguished British alienist) actually treats of mania and melancholia, of paranoid conditions, schizophrenic reactions and tension states, as well as of the condition which American psychiatrists group as "psychopathic personalities." The book consists of 9 chapters, each one describing a type of abnormal personality. The material is aimed at the intelligent, sophisticated non-medical reader. It is an excellent source book for the doctor who is preparing a public lecture. The style is lucid, smooth and interesting. Dr. Palmer even includes (and this is unusual in such books) some suggestions about treatment.

HERBERT BOEHM, M.D.

TUBERCULOSIS *Abstracts*

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXX November, 1957 No. 11

Tuberculosis—In and Out of Industry

By Reginald C. Edson, M.D., F.A.C.P., Industrial Medicine and Surgery, March, 1957.

● Current drug therapy and resection surgery have created a rapidly changing picture in tuberculosis treatment. More patients are returning to work while on chemotherapy. What effect do these developments have on the patients . . . the follow-up . . . and upon his capacity in industry?

These are changing times in tuberculosis. Death rates have fallen sharply and there has been a small but steady decline in incidence rates. New drugs and resection surgery have had so profound an effect that there is danger of over-optimism. Tuberculosis is far from eradicated.

The Problem

This year, approximately 50 persons in every 100,000 in the U. S. will develop tuberculosis. In 1955 of 100,000 new patients 75,000 had active disease. There were 15,000 people who died with tuberculosis. During this same year an increase in the number of new cases was reported by 15 states and the District of Columbia—and the District of Columbia and 6 states reported an increase in the number of deaths.

In the New England States in 1955 of 4,000 newly reported cases, 3,500 had active disease. There were 800 people who died with tuberculosis.

Management

How about the old familiar landmarks in the managements of tuberculosis—hospitalization, absolute bed rest, collapse therapy, sputum studies, x-rays, symptoms, exercise, work tolerance, rehabilitation and follow-up?

Active tuberculosis is best managed in the hospital. Absolute bed rest has been modified and is being evaluated under the protective umbrella of drug therapy. We are learning to use the new methods and evaluate the old, retaining whatever of the old that is good and replacing only when we have something better. Drug therapy, blood banks and advances in anesthesiology have contributed to the development of resection surgery. Wedge and segmental resections, lobectomy and pneumonectomy offer the advantage of removal of tuberculous tissue and have largely replaced collapse therapy measures, although pneumothorax and pneumoperitoneum are occasionally used, and plombage and thoracoplasty have a limited place in today's surgical procedures.

Drug therapy has cut down on the amount of sputum. In most patients conversion from positive to negative sputum occurs in three or four months. Sputum usually remains negative while the patients are on drugs but may revert to positive when drugs are discontinued. A series of negative sputum examinations on smear, culture and animal inoculations is of less prognostic significance if the patient is on drug therapy than it is after the drugs have been discontinued for three or more months.

Sensitivity studies on positive cultures guide changes in chemotherapy. Proper significance must be placed on "nonvirulent" and "nonpathogenic" acid fast organisms. Sputum examinations and the significance of sputum findings have indeed become complex.

Conventional x-ray examination, aided by body section laminagraphy, helps to determine stability. We still find bacteriological relapse with an unchanged x-ray picture, but today there is also the question of the "sterile cavity." Suffice it to say, cavity or bleb, sterile or non-sterile cavity—we prefer surgical removal when possible.

A feeling of well-being early in the course of recovery is the rule more so today than in the past. Graduated exercise, work tolerance and rehabilitation, like bed rest, are being modified and evaluated. Follow-up after discharge is important for the protection of the patient and for the

proper evaluation of today's changing picture of treatment and management.

As for chemotherapy the search is still on for the nontoxic, inexpensive bactericidal oral drug while today's drugs are used in conjunction with modified rest, supplemented by surgery when indicated. Drug therapy is usually used for all active disease. Streptomycin and isonicotinic acid hydrazide are major drugs. Para aminosalicylic acid is the most commonly used minor drug. Pyrezinamide and cycloserine are minor drugs that are more recently available. Because tubercle bacilli, resistant to available drugs have grown out when drugs are used singly—they are used in combination, preferably a major and a minor, keeping one of the majors in reserve. Isonicotinic acid hydrazide and para aminosalicylic acid or streptomycin and para aminosalicylic acid are two such combinations.

Exudative and pneumonic disease tends to resolve more rapidly than fibroid or cavitary disease. Definitive resection surgery properly timed during the course of drug therapy is used for selected cases.

How long the patient should be kept on drug therapy is not known, but it has been found necessary to increase the average time repeatedly. At present, in a general way, one might suggest as a minimum period of time on drug therapy: (a) for minimal pulmonary tuberculosis, a minimum of one year; (b) for advanced pulmonary tuberculosis, a minimum of 18 months; (c) for genitourinary, miliary and meningeal tuberculosis, a minimum of two years. These are minimum periods; drug therapy may be continued indefinitely beyond these minimum periods in the presence of continuing active disease.

The Future

Since the mean hospital stay is decreasing and the duration of drug therapy is increasing, a higher proportion of patients will be returning to work while still on drug therapy. Negative sputum needs to be confirmed when the drugs have been discontinued. Relapse rates under modern treatment are not available for a long enough period of time. However, preliminary trends suggest 8 per cent to 10 per cent, with over half of the relapse occurring within the first year after hospital discharge. Sputum examinations and x-ray comparisons continue to be the bulwark of follow-up.

Industry and Tuberculosis

How does this affect industry? The chest x-ray as part of a pre-employment examination gives the physician in industry a permanent and valuable record of the employee and indicates the need for medical investigation with a high degree of accuracy in chest disease. Mass chest x-ray examinations of all employees at stated intervals rounds out the advantages gained by pre-employment examination.

Differential diagnosis and the determination of activity in tuberculosis may be quite simple or extremely complex, and may be most easily carried out in the hospital. The employee who is known to have had active tuberculosis should be under adequate supervision. The patient who is on chemotherapy should have x-ray and sputum studies once a month. Follow-up may be provided by the family physician, by the hospital outpatient department, by the local health department, or by the Medical Department of the industry. The patient should be taught the value of a free exchange of information between these medical teams.

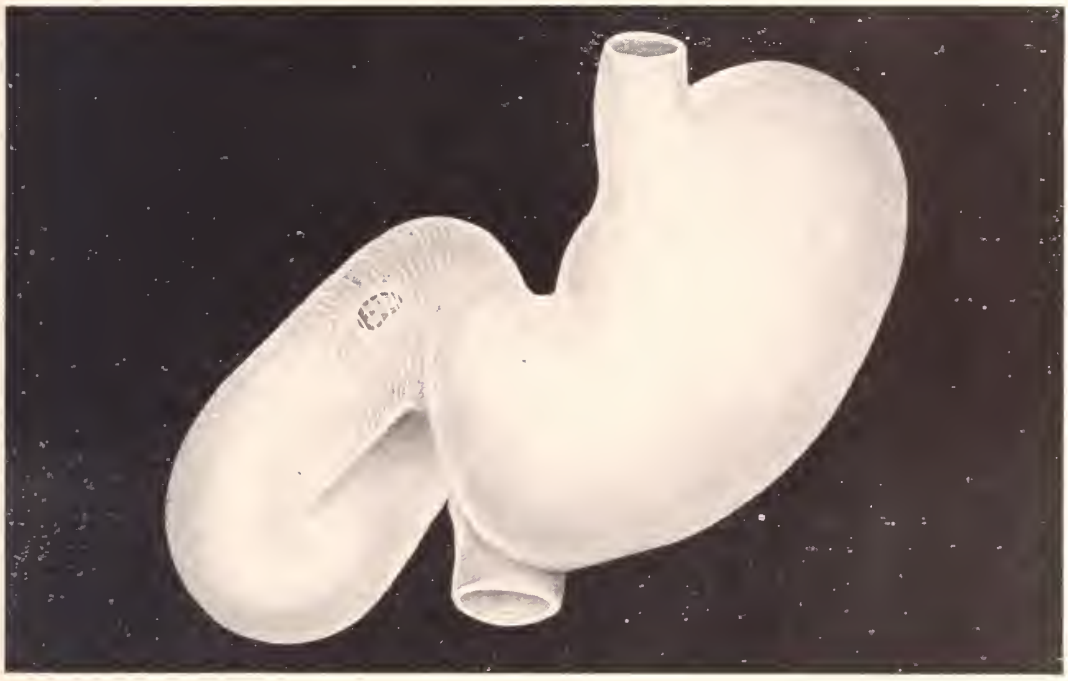
The patient who has had tuberculosis has always been a valuable asset to industry. He has learned to live moderately. He is usually on time, does his work well, and loses below average time for sick leave. The patient who is diagnosed early, treated by today's standards and adequately followed, will have less of a physical handicap than the patient who had tuberculosis 10 or more years ago; and he will, therefore, be an even greater asset to industry.

Summary

Tuberculosis is still with us; the death rate has fallen remarkably; the incidence is slowly decreasing; treatment is a rapidly changing picture; adequate follow-up protects the patient and industry; and the patient who has had tuberculosis is a valuable asset to industry.

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*Lichstein, J.; Morehouse, M. G., and Osmon, K. L.: Pro-Banthine in the Treatment of Peptic Ulcer. A Clinical Evaluation with Gastric Secretory, Motility and Gastroscopic Studies. Report of 60 Cases, Am. J. M. Sc. *232*:156 (Aug.) 1956.

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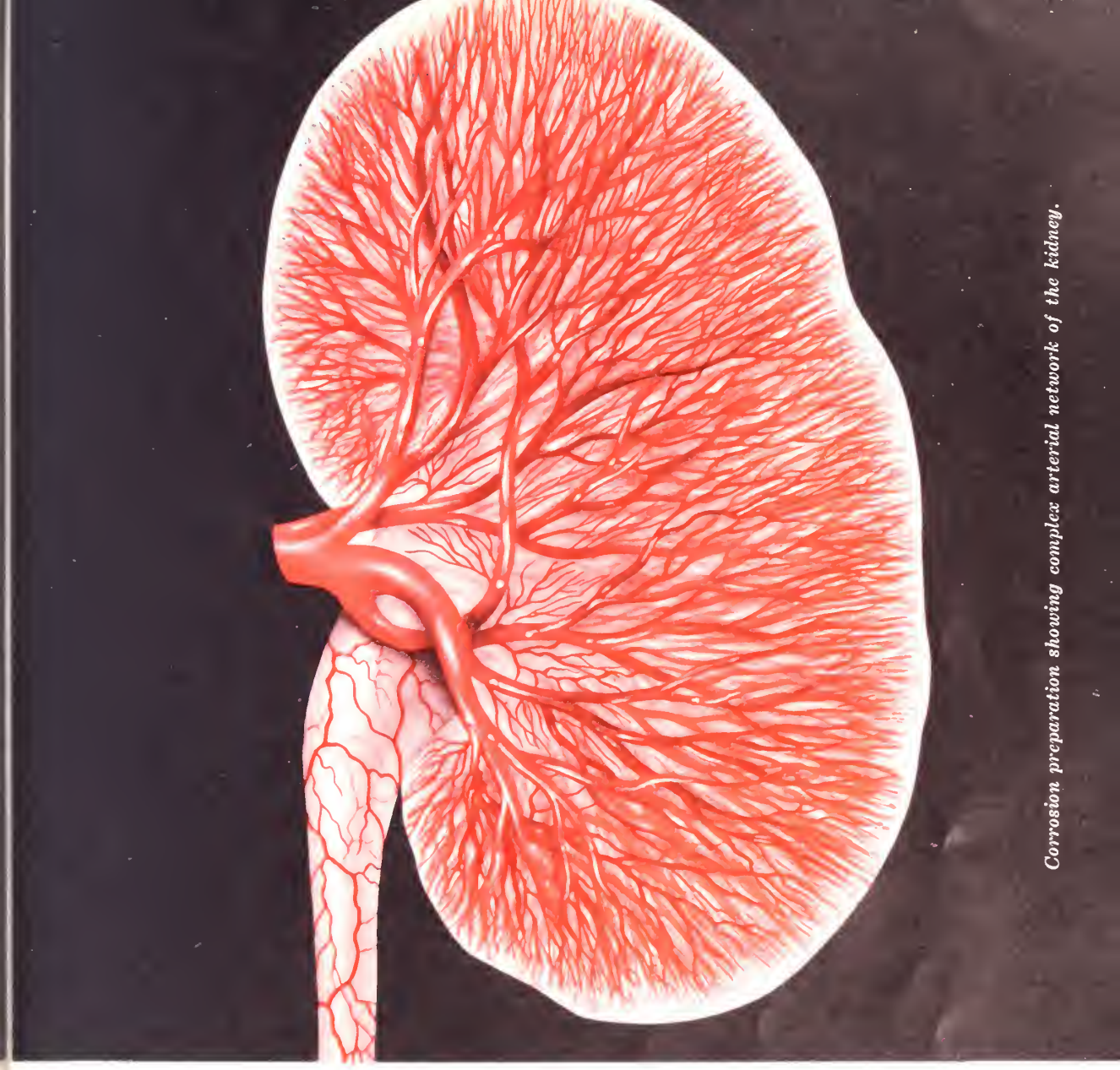
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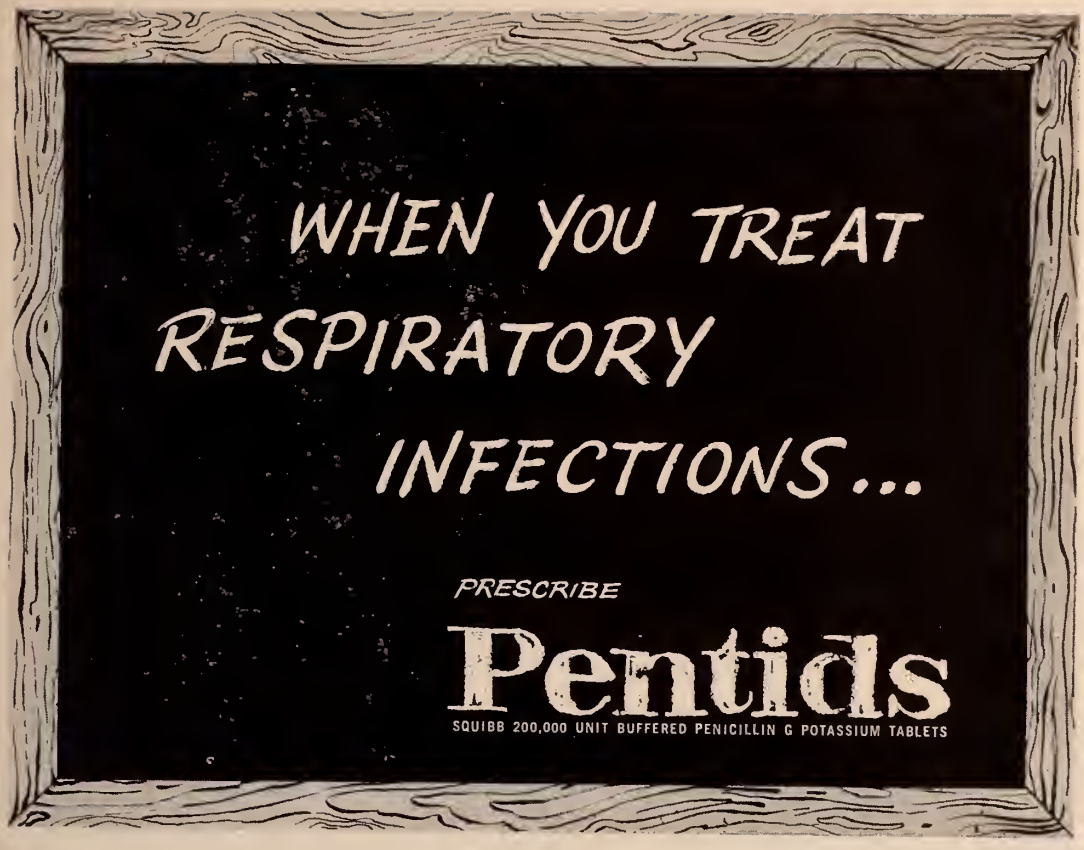
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*Stein, I.: Annals of Internal Medicine 45:185, 1956.

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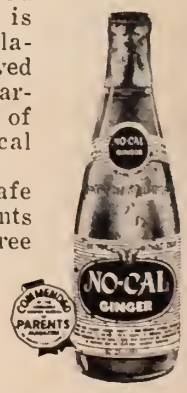


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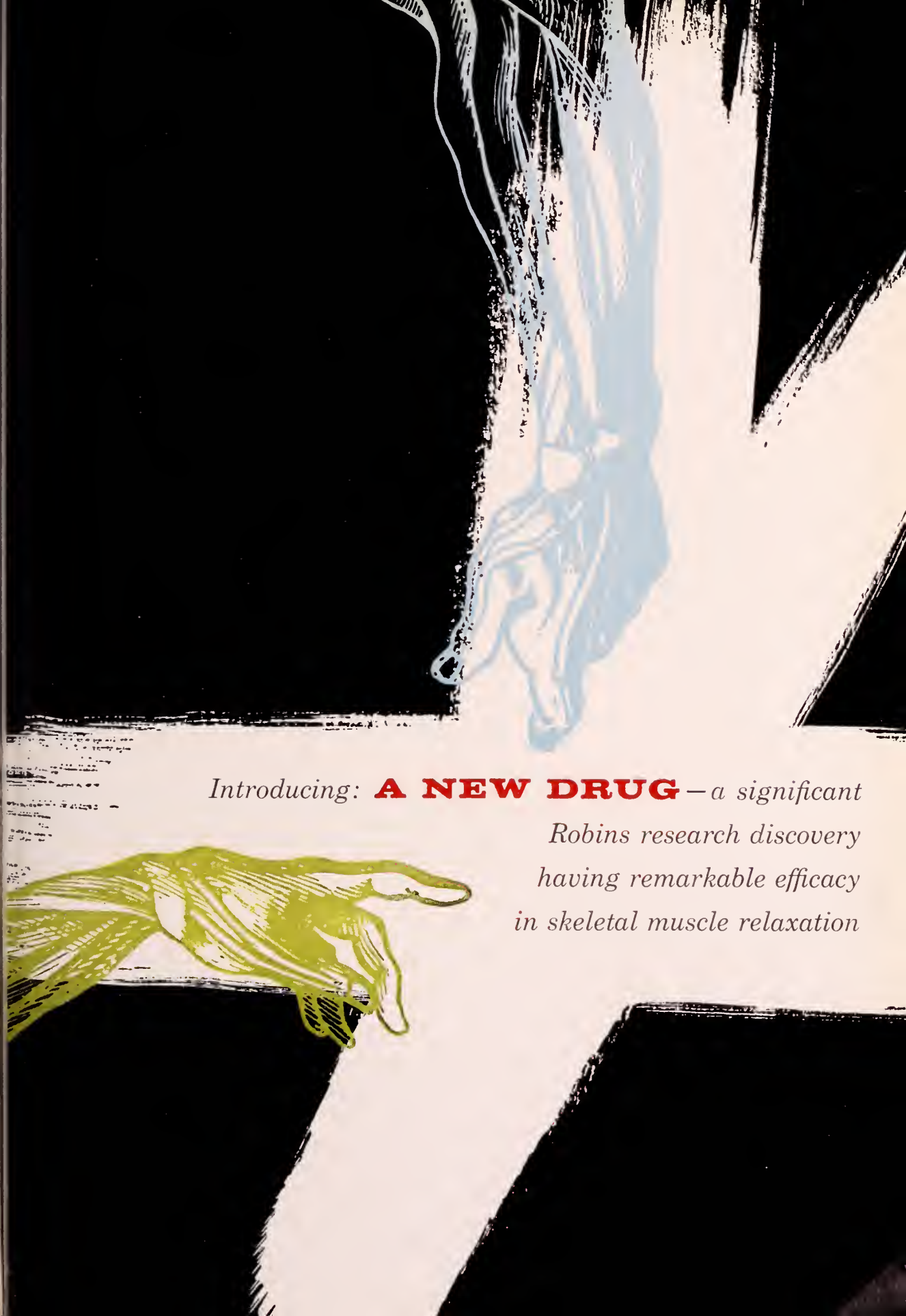
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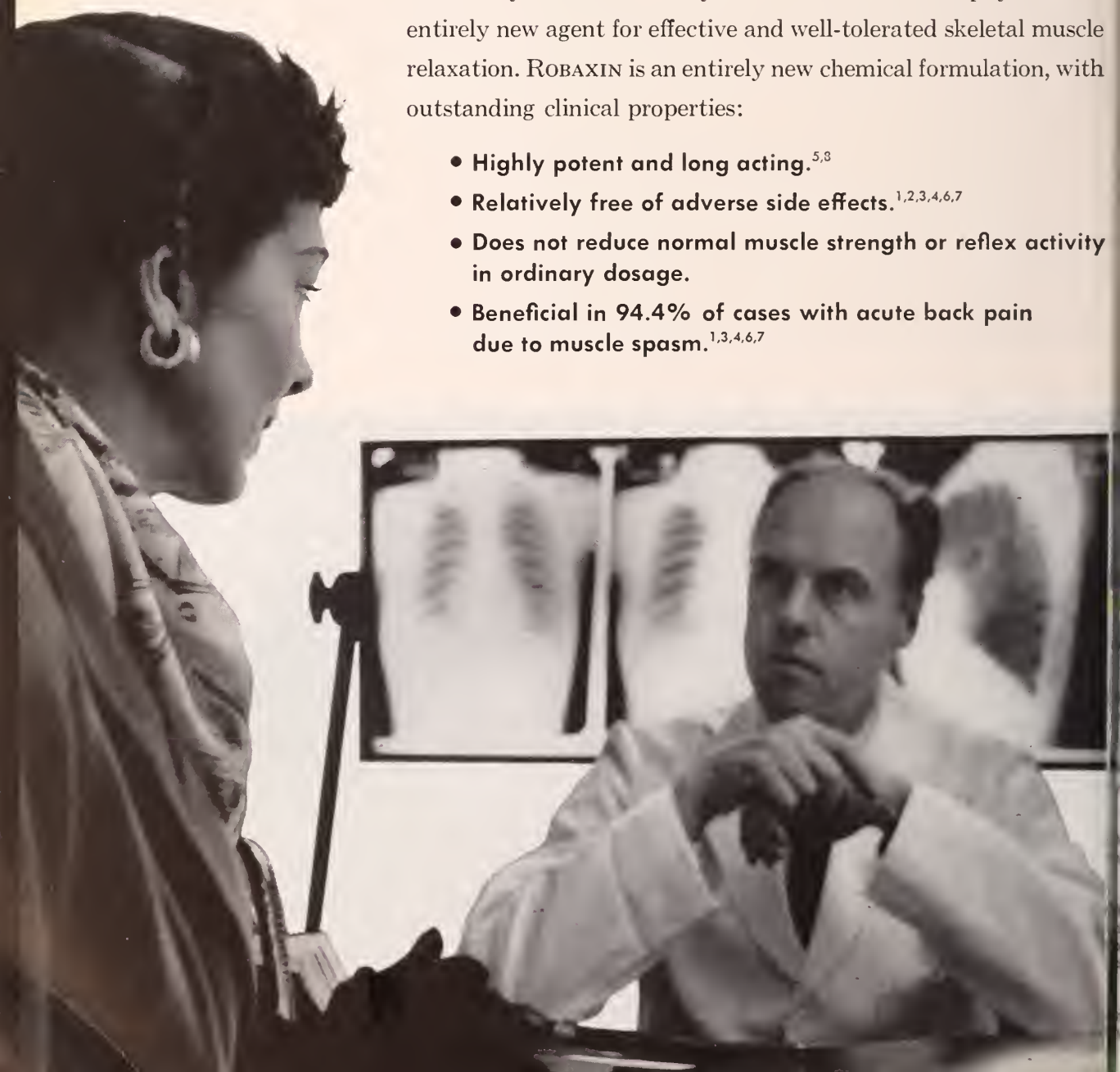
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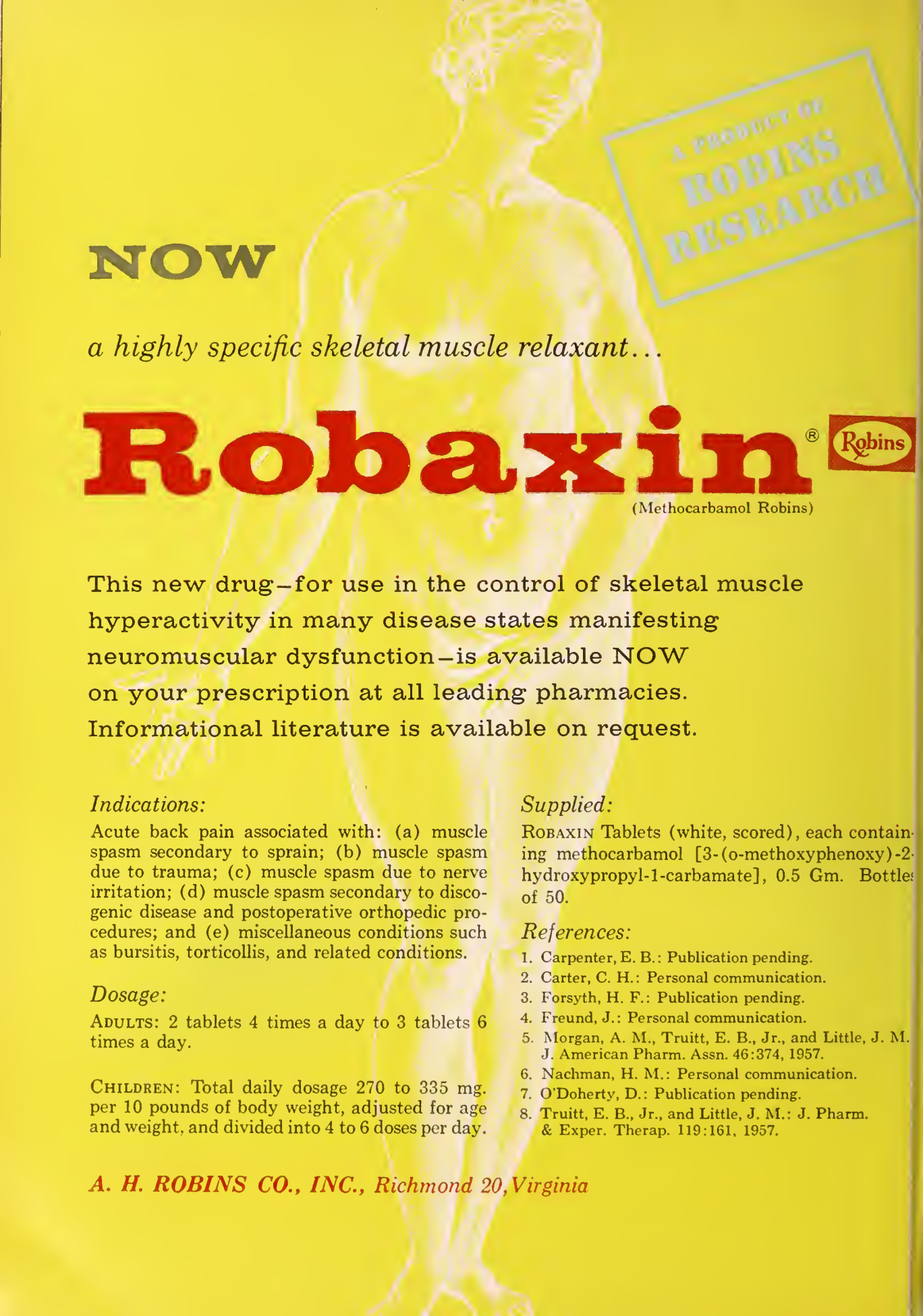
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				Marked	Mod.	Slight	Neg.	
e back pain due to								
luscle spasm secondary sprain	18	2-42 days	3-6 Gm.	17	1	0	0	None, 16; Dizziness, 1; Slight nausea, 1.
luscle spasm due to auma	13	1-42 days	2-6 Gm.	8	1	3	1	None, 12; Nervousness, 1.
luscle spasm due to erve irritation	5	4-240 days	2.25-6 Gm	4	1	0	0	None, 5.
luscle spasm secondary discogenic disease nd postoperative rthopedic procedures	30	2-28 days	1.5-9 Gm.	24	3	0	3	None, 25; Dizziness, 1; Lightheadedness, 2; Nausea, 2.*
ellaneous (bursitis, rticollis, etc.)	6	3-60 days	4-8 Gm.	6	0	0	0	None, 6.
TOTAL	72			59	6	3	4	



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References:

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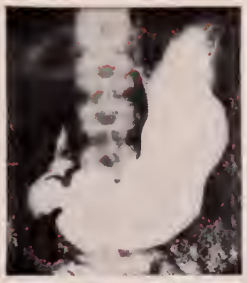
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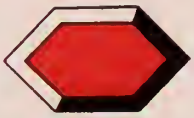
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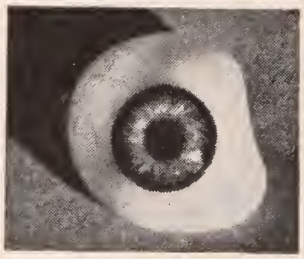


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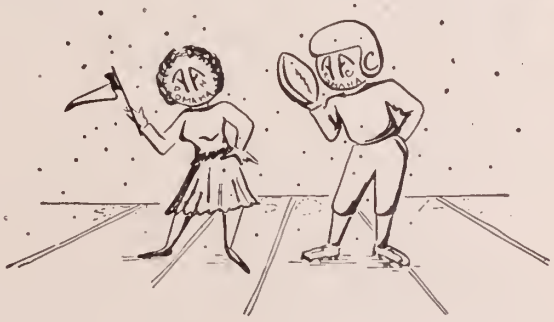
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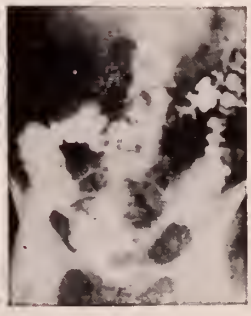
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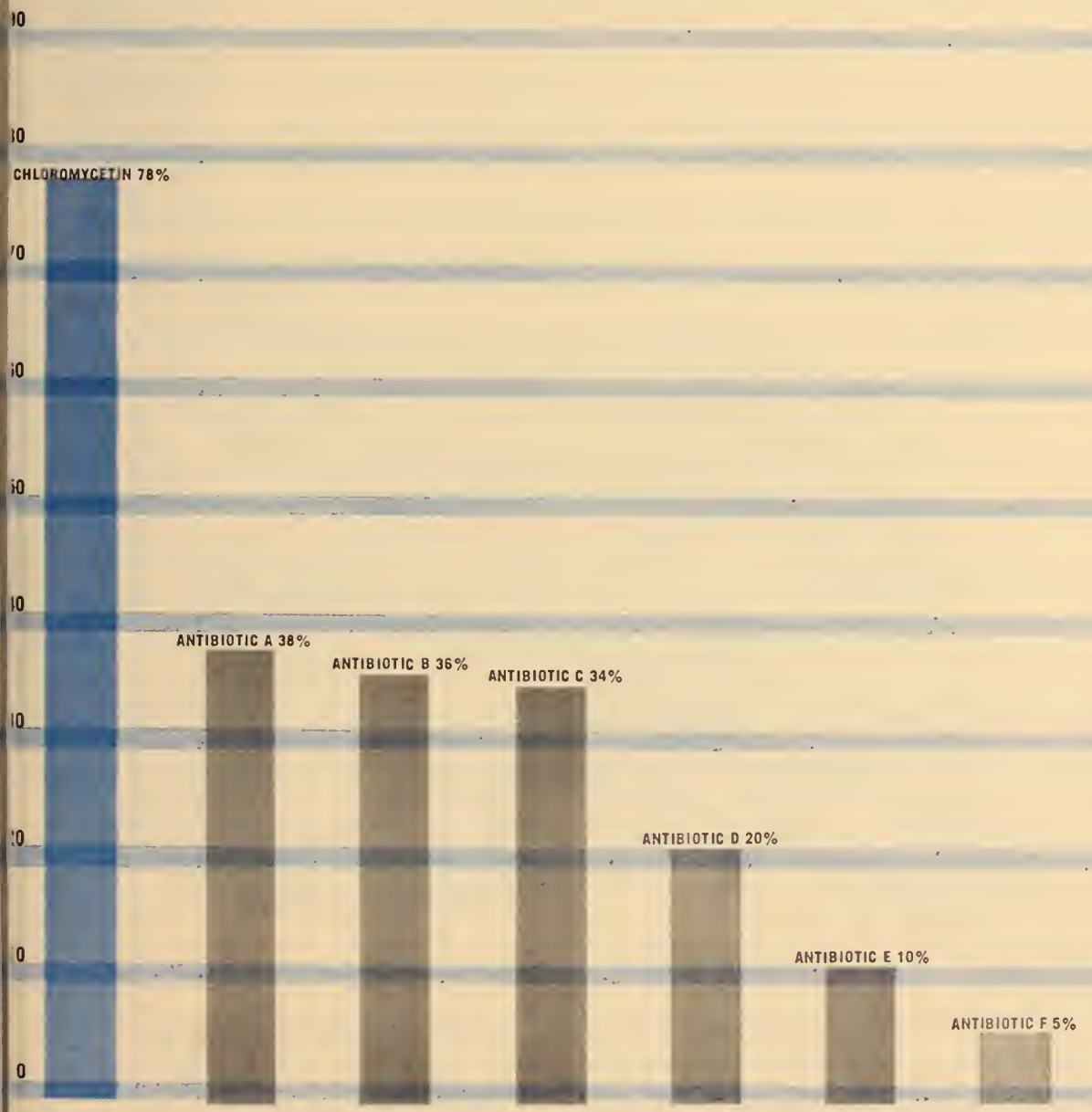
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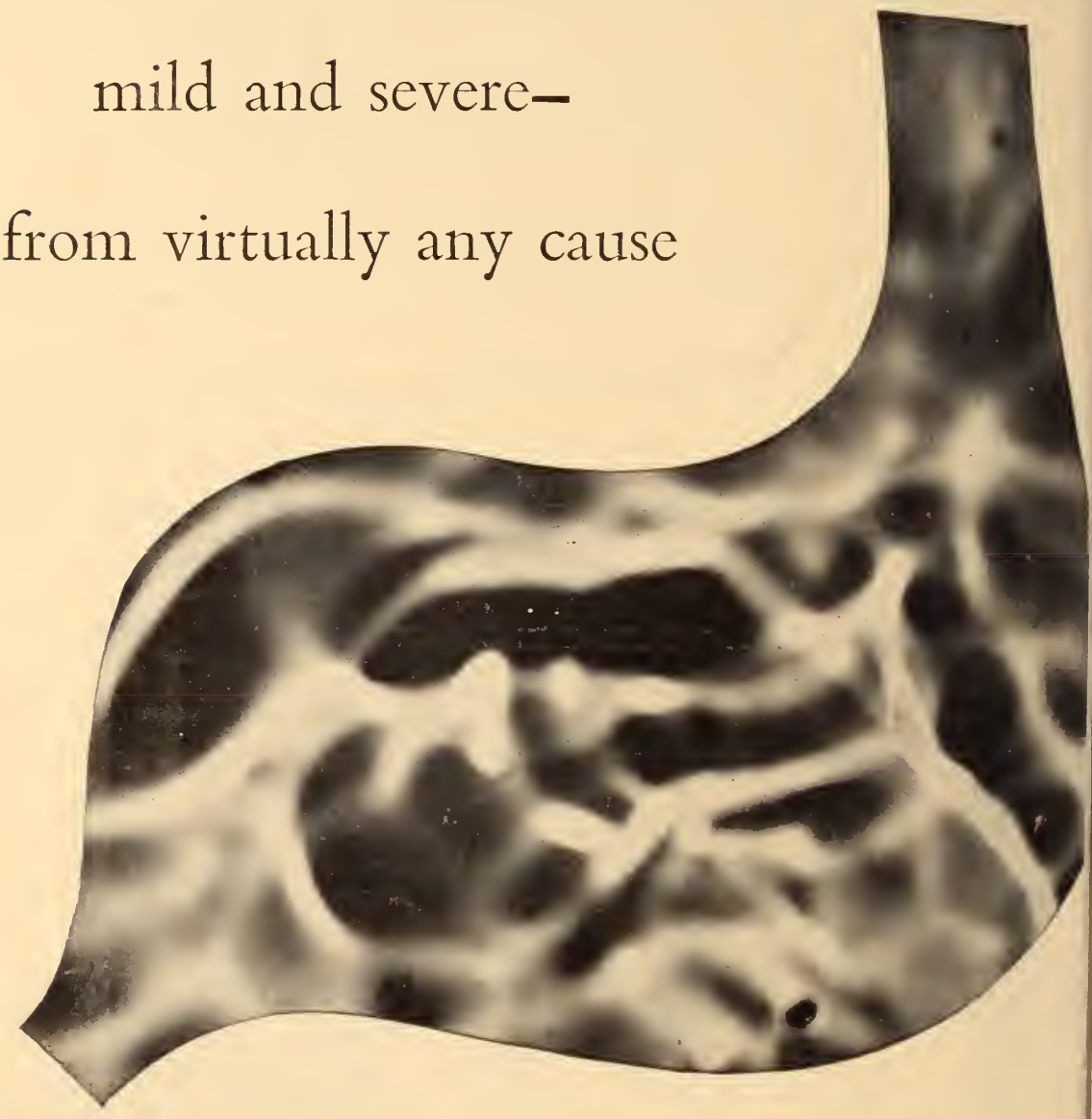


This graph is adapted from Waisbren and Strelitzer.[35] It represents *in vitro* data obtained with clinical material isolated between the years 1951 and 1956. Inhibitory concentrations, ranging from 3 to 25 mcg. per ml., were selected on the basis of usual clinical sensitivity.

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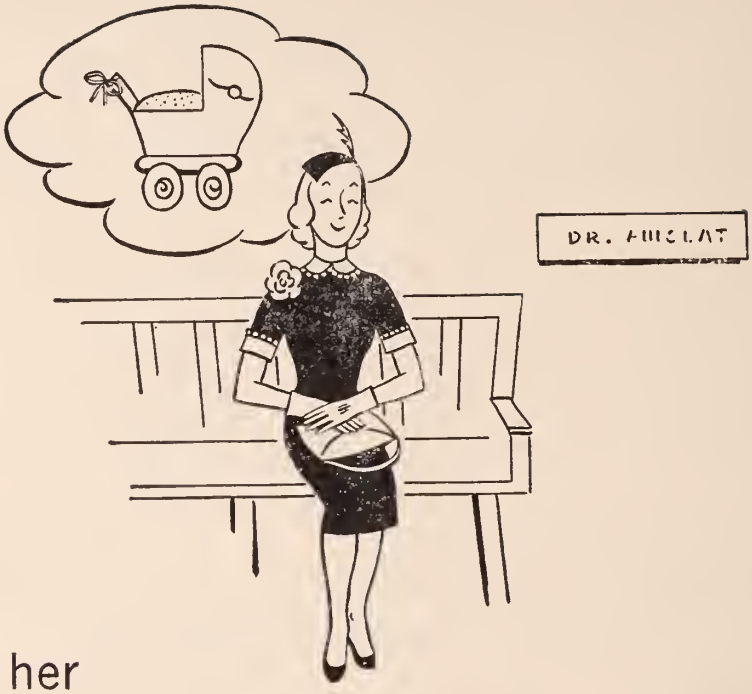
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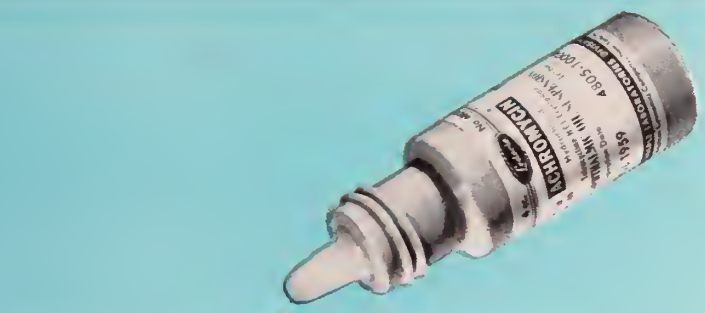
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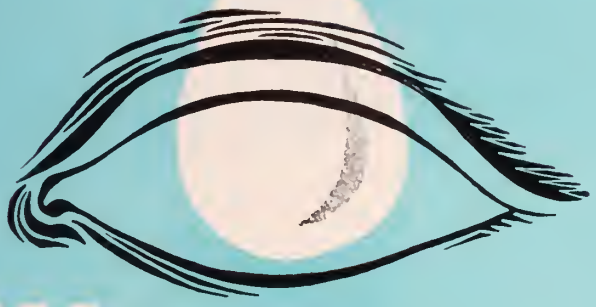
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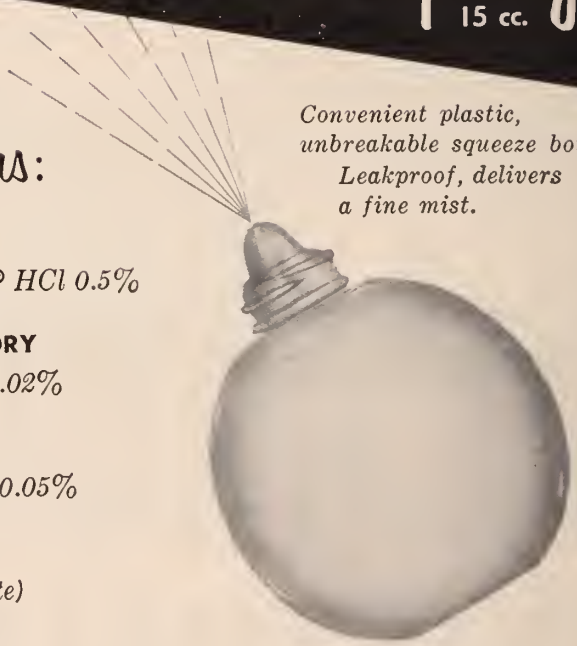
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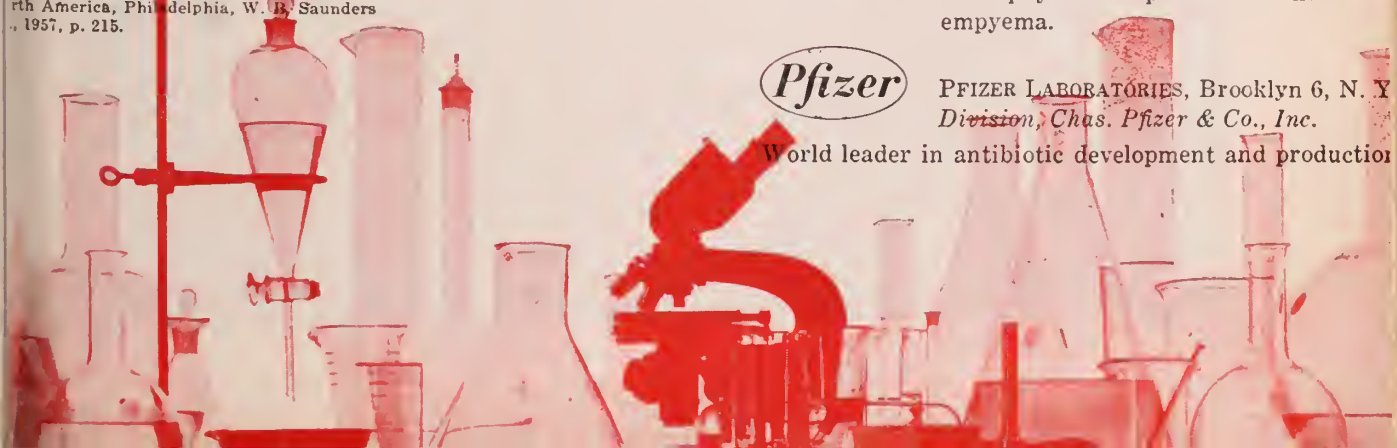
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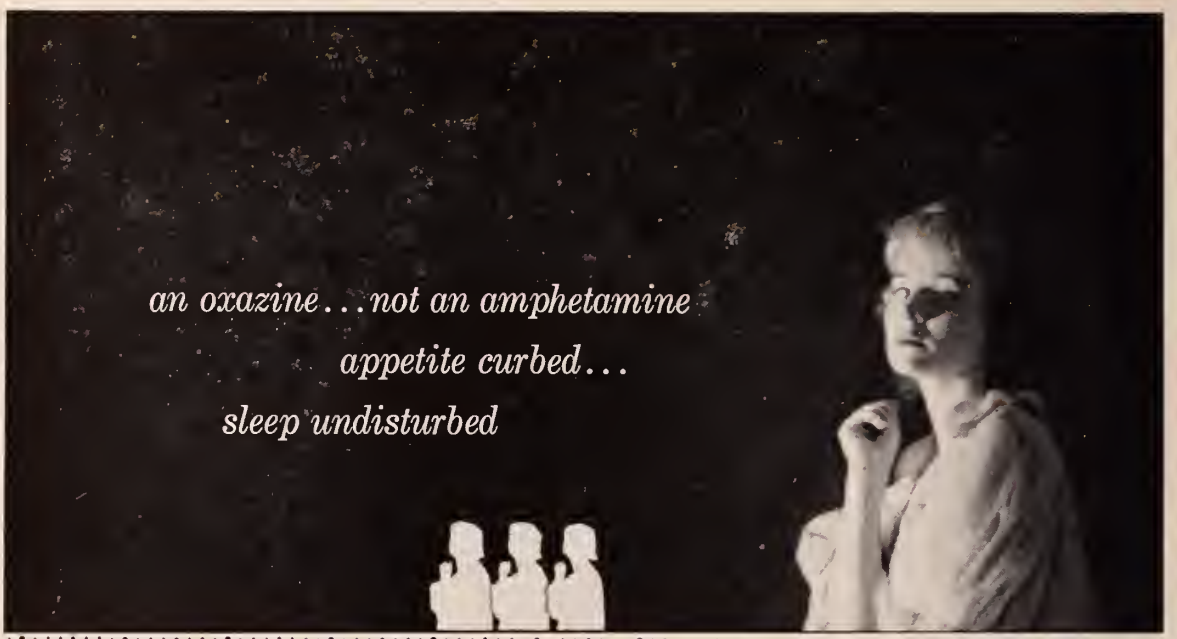
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For angina patients—perhaps the next one who enters your office—won't you consider new CARTRAX? This doubly effective therapy combines PETN (pentaerythritol tetranitrate) for lasting vasodilation and ATARAX for peace of mind. Thus CARTRAX relieves not only the anginal pain but reduces the concomitant anxiety.

Dosage and supplied: begin with 1 to 2 yellow tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. This may be increased for maximal effect by switching to *pink* tablets (20 mg. PETN plus 10 mg. ATARAX). In bottles of 100.

CARTRAX should be taken *before* meals, on a *continuous* dosage schedule. Use with caution in glaucoma.

1. Russek, H. I.: J. Am. Geriat. Soc. *4*:877 (Sept.) 1956.

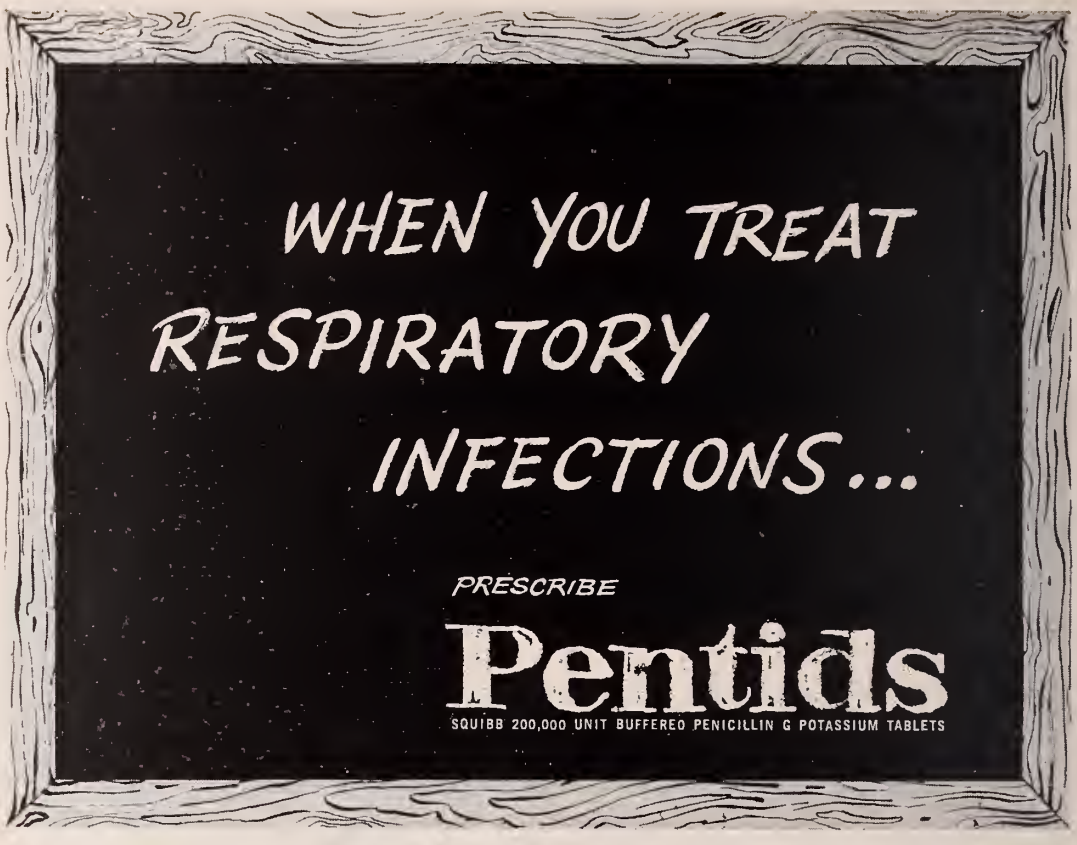
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- *excellent results with 1 or 2 tablets t.i.d. for many common bacterial infections*
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New authoritative studies prove that KYNEX dosage can be reduced even further than that recommended earlier.[1] Now, clinical evidence has established that a single (0.5 Gm.) tablet maintains therapeutic blood levels extending beyond 24 hours. Still more proof that KYNEX stands alone in sulfa performance—

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- Higher Solubility—effective blood concentrations within an hour or two
- Effective Antibacterial Range—exceptional effectiveness in urinary tract infections
- Convenience—the low dose of 0.5 Gm. (1 tablet) per day offers optimum convenience and acceptance to patients

NEW DOSAGE. The recommended adult dose is 1 Gm. (2 tablets or 4 teaspoonfuls of syrup) the first day, followed by 0.5 Gm. (1 tablet or 2 teaspoonfuls of syrup) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours. Dosage in children, according to weight; i.e., a 40 lb. child should receive ¼ of the adult dosage. It is recommended that these dosages not be exceeded.

TABLETS: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

SYRUP: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

1. Nichols, R. L. and Finland, M.: *J. Clin. Med.* 49:410. 1957.

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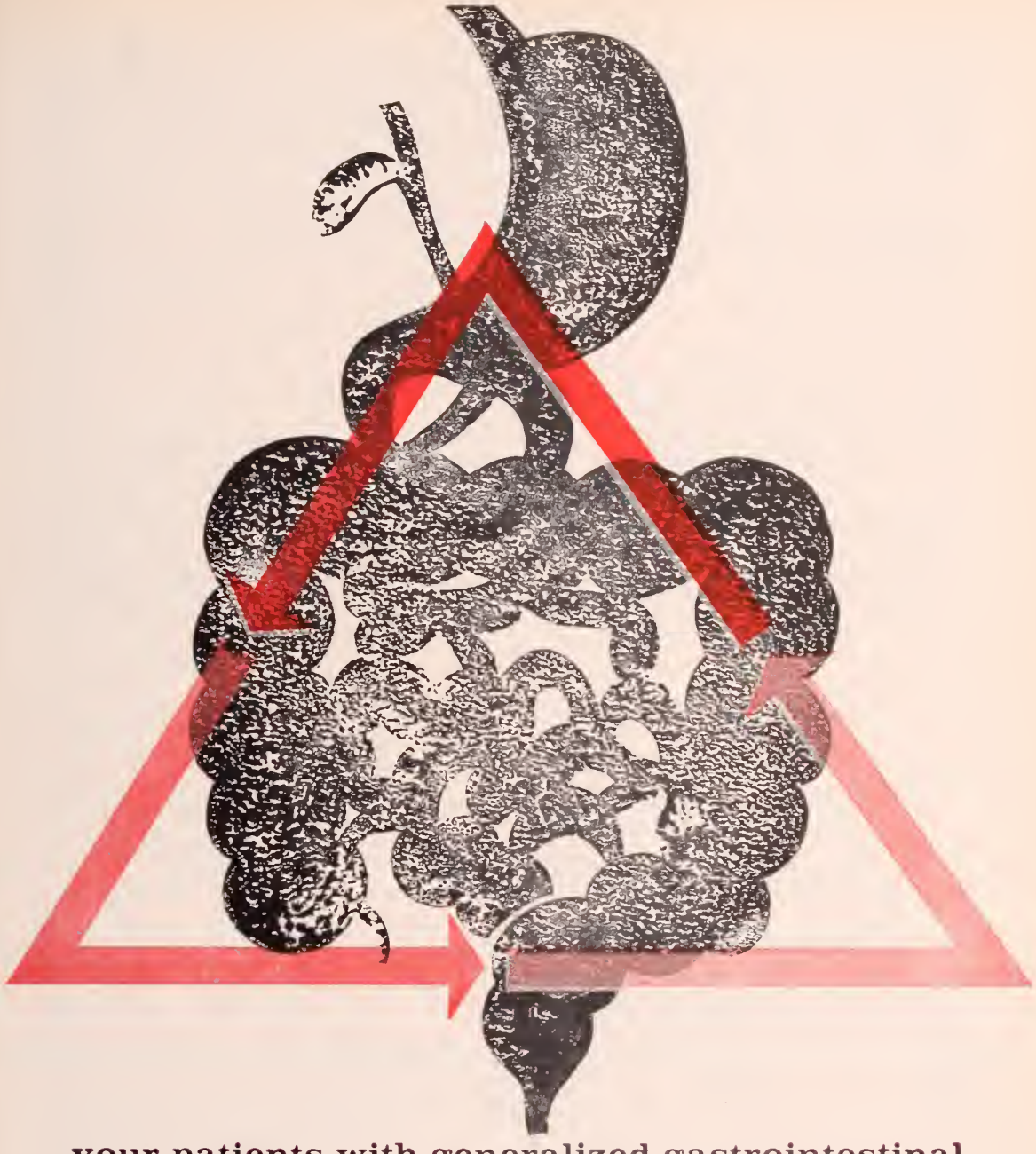
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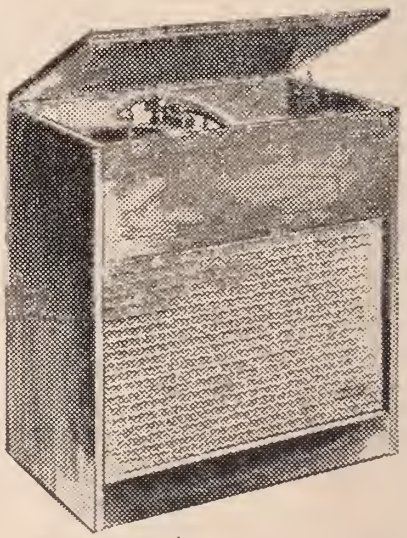
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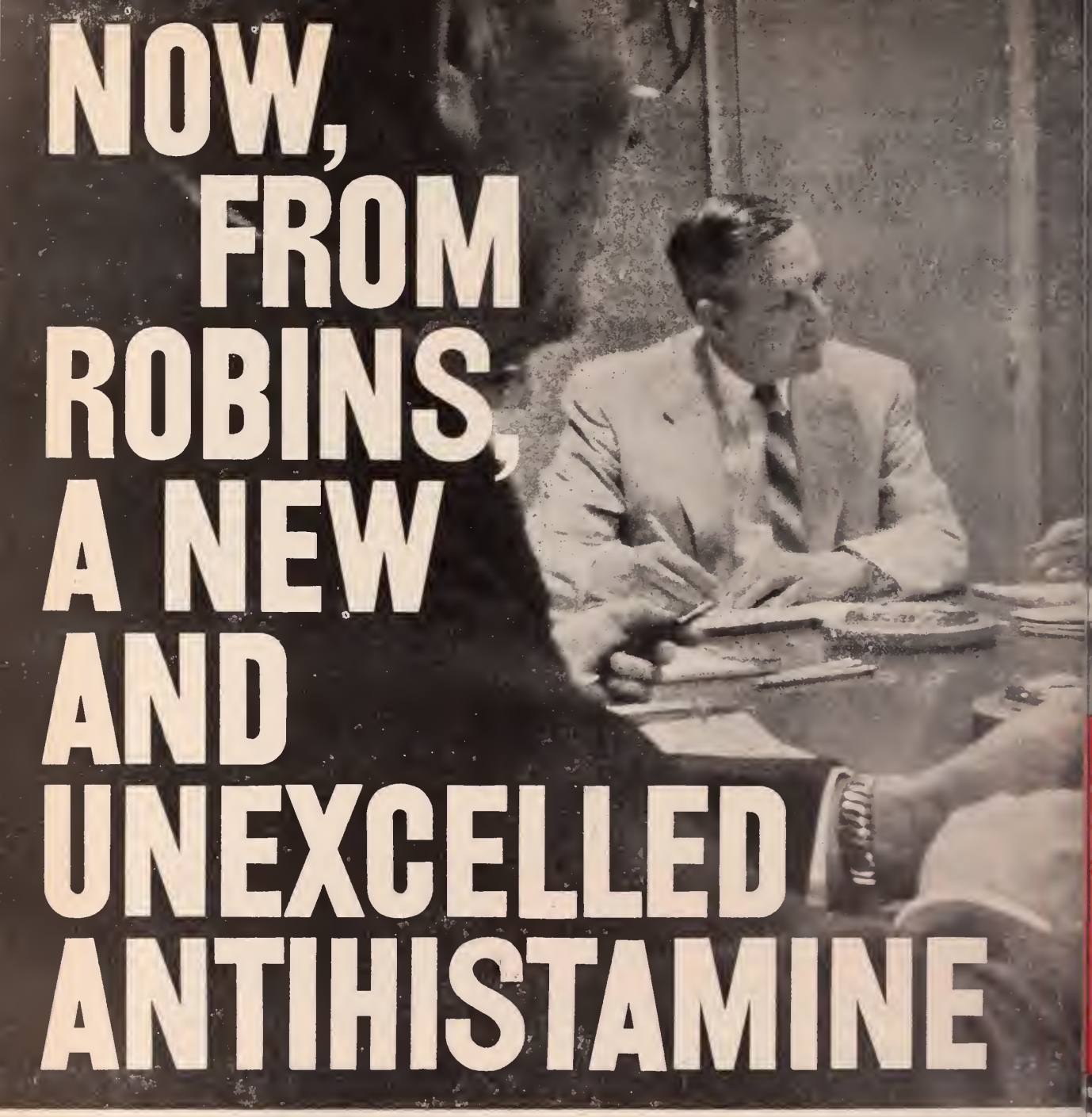
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» unexcelled antihistaminic action

Diagnosis	No. of Patients	Response				Side Effects
		Excellent	Good	Fair	Negative	
Allergic rhinitis and vasomotor rhinitis	30	14	9	5	2	Slight Drowsiness (3)
Urticaria and angioneurotic edema	3	1	1	1		Dizzy (1)
Allergic dermatitis	2		1	1		Slight Drowsiness (2)
Bronchial asthma	1		1			
Pruritus	1		1			
Total	37	15	13	7	2	Drowsiness (5) Dizzy (1) 16.2%

From the preliminary **Dimetane Extentabs** studies of three investigators. Further clinical investigations will be reported as complete



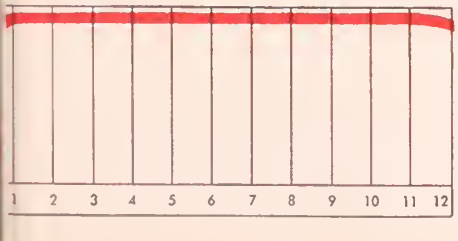
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a blanket of allergic protection, covering 10-12 hours—with just one Dimetane Extentab » *DIMETANE Extentabs protect patient for 10-12 hours on one tablet.*



Periods of stress can be easily handled with supplementary DIMETANE Tablets or Elixir to obtain maximum coverage.

Dosage:

Adults—One or two 4-mg. tabs. or two to four teaspoonfuls Elixir, three or four times daily. One Extentab q.8-12 h. or twice daily.

Children over 6—One tab. or two teaspoonfuls Elixir t.i.d. or q.i.d., or one Extentab q.12h.

Children 3-6—½ tab. or one teaspoonful Elixir t.i.d.

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ARALEN® *in* RHEUMATOID ARTHRITIS

Extensive studies of rheumatoid arthritis and related collagen diseases—in this country and abroad—have shown the antimalarial Aralen phosphate to be highly effective and well tolerated in a large percentage of patients.

Clinical Results with Aralen in Rheumatoid Arthritis

Author	No. of Cases	Major Improvement	Minor Improvement	No Effect
Haydu[1]	28	22	5	1
Rinehart[2]	25	12	4	9
Freedman[3]	50	43	3	4
Bagnall[4]	108	77	12	19
Bruckner[5]	36	32	0	4
Cohen and Calkins[6]	22	17	3	2
Scherbel et al.[7]	25	9	8	8
Total	294	212 (72%)	35 (12%)	47 (16%)

- Success dependent upon persistent treatment
- Often of benefit where other agents have failed
- Remissions on therapy well maintained
- Remission of 3 to 12 months possible even if treatment is interrupted
- Tachyphylaxis not evident

GENERAL EFFECTS:

- Patient feels better
- Patient looks better
- Exercise tolerance increases
- Walking speed and hand grip improves

LABORATORY EFFECTS:

- E. S. R. may fall slowly

ANALGESICS AND STEROIDS:

- Requirements usually reduced or eliminated

JOINT EFFECTS:

- Pain and tenderness relieved
- Mobility increases
- Swellings diminish or disappear
- Muscle strength improves
- Rheumatic nodules may disappear
- Even severe or advanced deformity may improve
- *Active* inflammatory process usually subsides
- Joint effusion may diminish

DOSAGE:

Aralen is cumulative in action and requires four to twelve weeks of administration before therapeutic effect become apparent.

Latest information indicates that an initial dai dose of 250 mg. of Aralen phosphate is prefera to the higher doses sometimes recommended. However, if side effects appear, withdraw Aralen for several days until they subside. Reinstate treatment with 125 mg. daily and, if well tolerated, increase to 250 mg. The usual maintenance dose is 250 mg. daily.

New Chemotherapy

INDICATIONS:

- Rheumatoid arthritis, acute or chronic —with or without adjunctive therapy.
- Spondylitis
- Arthritis associated with lupus erythematosus or psoriasis

THEORY OF ACTION:

Aralen appears to suppress or induce remission of rheumatoid inflammatory processes by inhibiting adenosinetriphosphatase.

HOW SUPPLIED:

Aralen phosphate: 250 mg. tablets in bottles of 100 and 1000.
125 mg. tablets in bottles of 100.

Tolerance:

Aralen is usually well tolerated. Toxic effects are usually mild and to date have been transitory in nature, disappearing completely either on continuance or cessation of therapy or on reduction in dosage.

Gastrointestinal disturbances (e.g. nausea, rarely vomiting, diarrhea, abdominal cramps, anorexia) are frequent manifestations of intolerance. Temporary blurring of vision (due to interference with accommodation) is also relatively frequent.

Pleomorphic skin eruptions (e.g. lichenoid, maculopapular, purpuric), although generally mild, may preclude the use of an optimum dosage schedule. If a skin reaction persists on a reduced dosage schedule, or recurs after reinstitution of treatment with gradually increasing doses, discontinue Aralen till the lesion again disappears and consider resuming treatment with Plaquenil® (brand of hydroxychloroquine).

Less frequently transitory vertigo, headache, lassitude, or neurological disturbances, such as nervousness, irritability, emotional change, and nightmares have been reported. Instances of unexplained slight gradual weight loss as the patient's general health and arthritic condition improved have been mentioned. Occasional instances of bleaching (depigmentation) of the hair have been described.

Although an occasional instance of leukopenia, with normal differential count, has been reported (WBC about 3000), it has not proved troublesome because it has always been reversible on discontinuance, or diminution of the dose. Even spontaneous reversal may occur while full dosage is maintained.

Caution:

Aralen is known to concentrate in the liver and, although hepatic damage has never been reported, the drug should be used with caution in the presence of liver disease. In the presence of severe gastrointestinal, neurological, or blood disorders, the drug should be used with caution or not at all. If such disorders occur during the course of therapy, the drug should be discontinued. Concomitant use of gold or phenylbutazone with Aralen should be avoided because of the tendency of these agents to produce drug dermatitis.

Clinical Comments:

Of fifty patients receiving Aralen therapy, "43 have become really well; that is, they have no stiffness, and any pain that occurs can reasonably be attributed to use of joints affected by secondary degenerative changes. They have no evidence of joint inflammation, but may have a raised erythrocyte sedimentation rate. They have little or no need for analgesics." *Freedman*[3]

"One hundred and twenty-five private patients have been carefully followed clinically and haematologically while receiving well over 200 patient-years of chloroquine [Aralen] therapy. The results are considered good in 70%, one-half of these cases being in remission. Improved work performance, sedimentation rate, and hemoglobin levels paralleled the major objective gain in this 70%. 90% of them remained on chloroquine [Aralen] therapy, half for more than two years. Classical peripheral rheumatoid arthritis, spondylitis, arthritis of juvenile onset, and rheumatoid disease with psoriasis, all appeared to respond about equally well.

"It is suggested that chloroquine comes closer to the ideal for long-term, safe, control of rheumatoid disease than any other agent now available." *Bagnall*[4]

"Out of the 36 rheumatoid arthritis cases we treated . . . favorable results were obtained in 32 cases. *Bruckner et al.*[5]

References

1. Hayden, G. G.: Rheumatoid arthritis therapy, a rationale and the use of chloroquine diphosphate, *Am. J. M. Sc.* 225:71, Jan., 1953.
2. Ringhart, R. F.: Chloroquine therapy in rheumatoid arthritis, *Northwest Med.* 54:713, July, 1955.
3. Freedman, A.: Chloroquine and rheumatoid arthritis, a short-term controlled trial, *Ann. Rheum. Dis.* 15:251, Sept., 1956.
4. Bagnall, A.W.: The value of chloroquine in rheumatoid disease, a four year study of continuous therapy, read at the Ninth International Congress on Rheumatic Diseases in Toronto, Canada, June 23-28, 1957.
5. Bruckner, L. and Rozenzweig, S.: Treatment of chronic rheumatoid arthritis with synthetic antimalarials, read at the Ninth International Congress on Rheumatic Diseases in Toronto, Canada, June 23-28, 1957.
6. Cohen, A.S., and Calkins, Evan: A controlled study of chloroquine as an antirheumatic agent, read at the Ninth International Congress on Rheumatic Diseases in Toronto, Canada, June 23-28, 1957.
7. Scherlis, A. L., Schechter, S.L., and Harrison, J.W.: Comparison of effects of two

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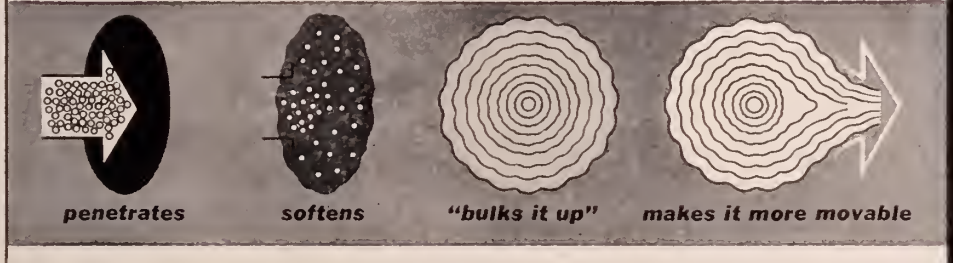
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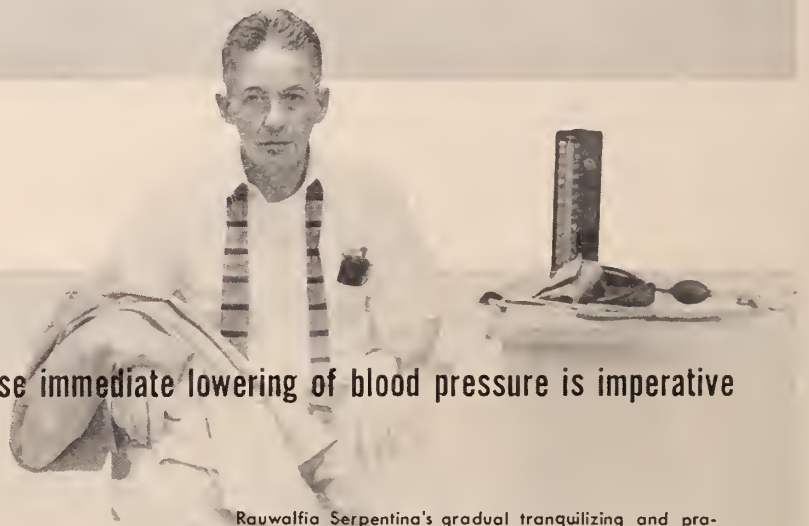
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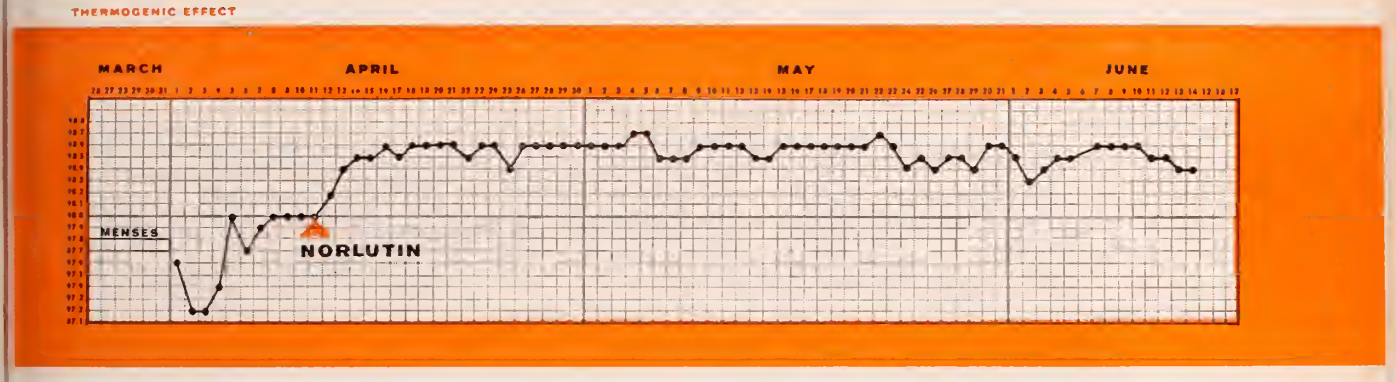
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major advance in female hormone therapy for certain disorders of menstruation and pregnancy

INDICATIONS FOR NORLUTIN: conditions involving deficiency of progestogen, such as primary and secondary amenorrhea, menstrual irregularity, functional uterine bleeding, endocrine infertility, habitual abortion, threatened abortion, premenstrual tension, and dysmenorrhea.

PACKAGING: 5-mg. scored tablets (C. T. No. 882), bottles of 30.

*Greenblatt, R. B.: *J. Clin. Endocrinol.* 16:869, 1956.

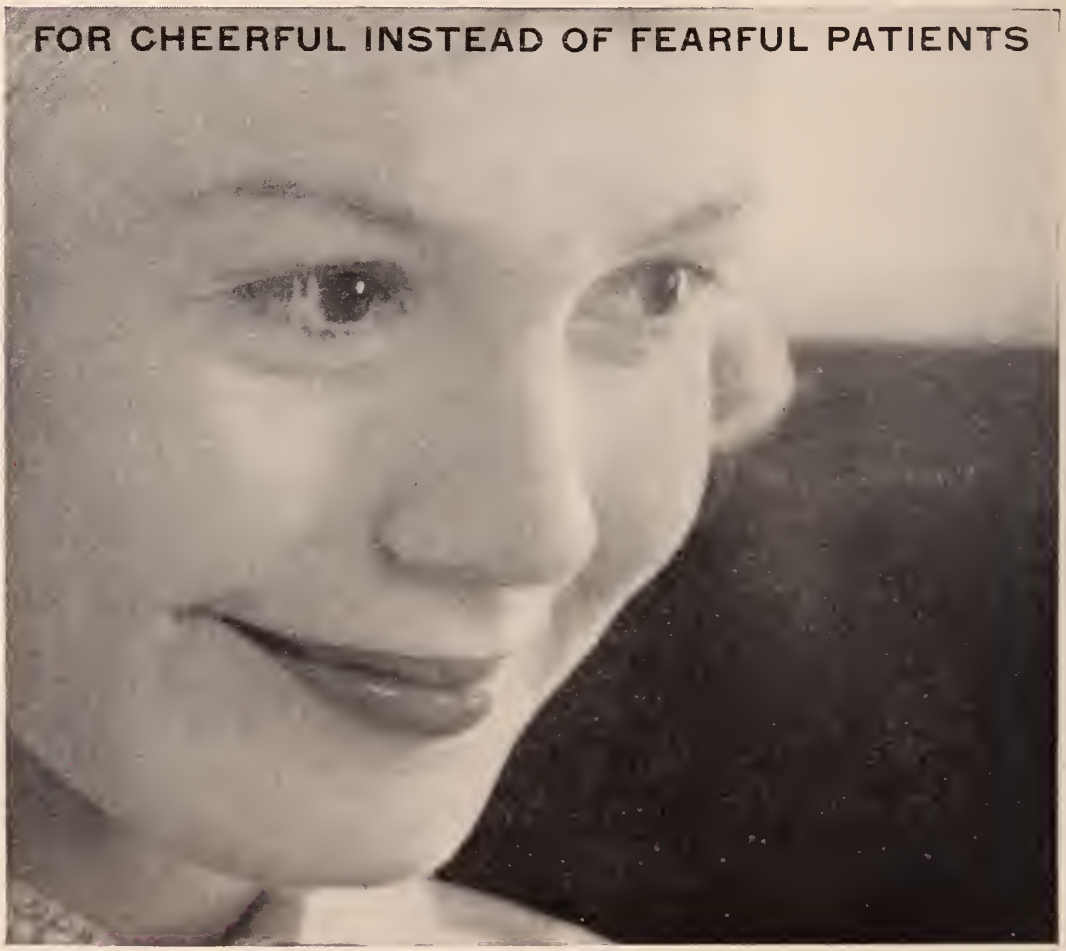
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New Isuprel-Franol tablets bring round-the-clock relief *plus* emergency help against sudden attack. Anxiety stops when patients know they'll get relief in 60 seconds — relief that continues for four hours or more.

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Isuprel-Franol tablets are "... effective in controlling over 80% of patients with mild to moderate attacks of asthma."[1]

1. Fromer, J. L., and DeRisio, V. J.: *Lahey Clin. Bull.* 10:45, Oct.-Dec., 1956.

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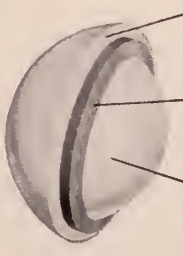
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Isuprel-Franol Tabs
#20 100

Sig 1 tablet t p d
If attack occurs,
place 1 tablet under
tongue, swallow after
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ISUPREL-FRANOL tablets (Isuprel HCl 10 mg.) for adults;
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One tablet every three or four hours taken *orally* for continuous control of bronchospasm in chronic asthma. One tablet taken *sublingually* for sudden attack. "Flavor-timer" signals when patient should swallow.
Bottles of 100 tablets.

"Flavor-timer" signals patients when to swallow tablets



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(1) Asung, C. L.; Charcowa, A. I., and Villa, A. P.: Sea View Hosp. Bull. *16*:80, 1956. (2) Asung, C. L.; Charcowa, A. I., and Villa, A. P.: New York J. Med. *57*:1911 (June 1) 1957. (3) Report on Field Screening of Nostyn by 99 Physicians in 1,000 Patients, June, 1956.

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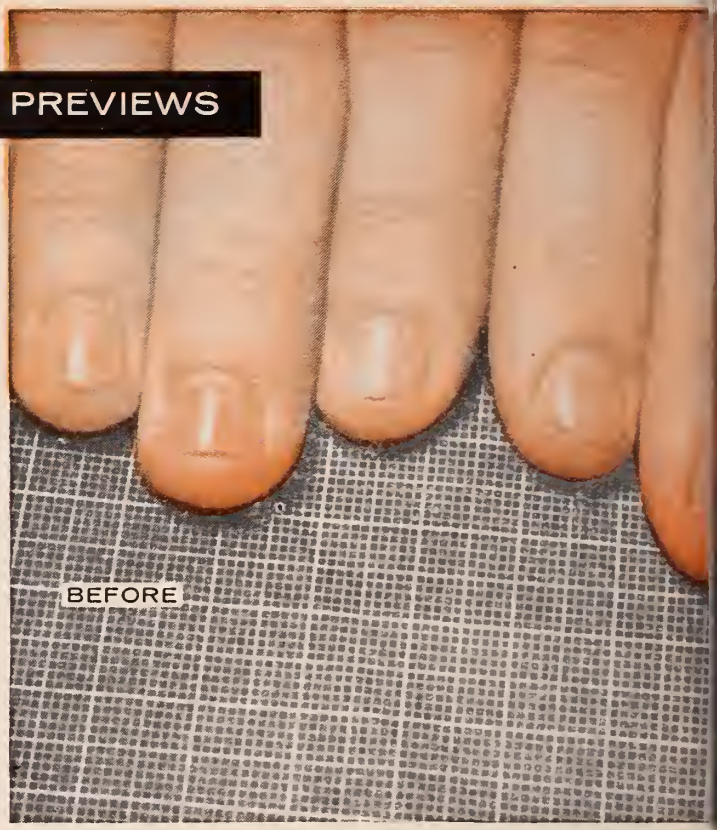
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KNOX PROTEIN PREVIEWS



TWO NEW CLINICAL REPORTS REAFFIRM THE BENEFITS OF **GELATINE FOR**





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Evidence continues to accumulate verifying the effectiveness of Gelatine in the treatment of brittle fingernails. Investigators report that the nails show objective evidence of improvement.[1,2,3,4] Furthermore, patients often volunteer that their nails "feel stronger," "look smoother," and "I can pick up things without them hurting."[1] Evidently the subjective sensations associated with improvement are nearly as important to some patients as the positive physical change in the nails' appearance.

Improvement Noted in 81% of Patients

See the chart below for a summary of the effect of Knox Gelatine in brittle fingernails as observed in all published reports. Photographic evidence of improvement, much of it in color taken before and during treatment, is available for most of the patients.[1,2,3] Please note, however, that where Gelatine was used in the treatment of pathological conditions associated with brittle fingernails only in psoriasis did the data show definite improvement.[1,3,4]

Response to Gelatine in Brittle Fingernails

References	Dosage	Duration of treatment	No. patients w/ brittle nails	No. patients improved	No. patients w/ brittle nails and other pathology	No. patients improved
1. Rosenberg, S., Oster, K. A., Kallos, A. and Burroughs, W.: *A.M.A. Arch. Dermat* 76:330, (September) 1957	7 Gm./day	3 months	50	43 (86%)	32[a]	9
2. Schwimmer, M. and Mulinos, M.G. *Antibiot. Med. & Clin. Therapy* 4 403, (July) 1957	7.5 Gm./day	11-16 weeks	18	15 (83%)		
3. Rosenberg, S. and Oster, K. A.: *Conn. State Med. J* 19:171, (March) 1955	7 to 21 Gm./day	15 weeks	36	26[b] (72%)		
4. Tyson, T. L.: *J. Invest. Dermat* 14:323, (May) 1950	7 Gm./day	13 weeks	12	10[c] (83%)		
Totals	7-21 Gm.	11-16 weeks	116	94 (81%)	32	9 (28%)

a. Gelatine improved psoriatic nails in 5 out of 12 cases. In onychomycosis and other pathological conditions of the nail it was of no appreciable help.

b. Of the failures, 2 had congenital disease of the nails, 3 were diabetics and 3 took the medication for less than one month.

c. One patient with psoriasis and arthritis and one patient with psoriasiform nail changes showed improvement in 2 and 3 months respectively.

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Knox Gelatine Company
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Johnstown, N. Y.

Please send reprints of the following articles:

☐ Rosenberg, S., Oster, K. A., Kallos, A. and Burroughs, W.: *A.M.A. Arch. Dermat.* 76:330, (Sept.) 1957.

☐ Schwimmer, M. and Mulinos, M.G.: *Antibiot. Med. & Clin. Therapy* 4:403, (July) 1957.

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1. Hodges, F. T.: GP, *14*:86, Nov., 1956.

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References
1. King, J. H., Jr.; Passmore, J. W.; Skeehan, R. A., Jr., and Weimer, J. R.: Tr. Am. Acad. Ophth. *59*:759, 1955.
2. Kuhn, H. S.: Tr. Am. Acad. Ophth. *55*:431, 1951.

*T. M.

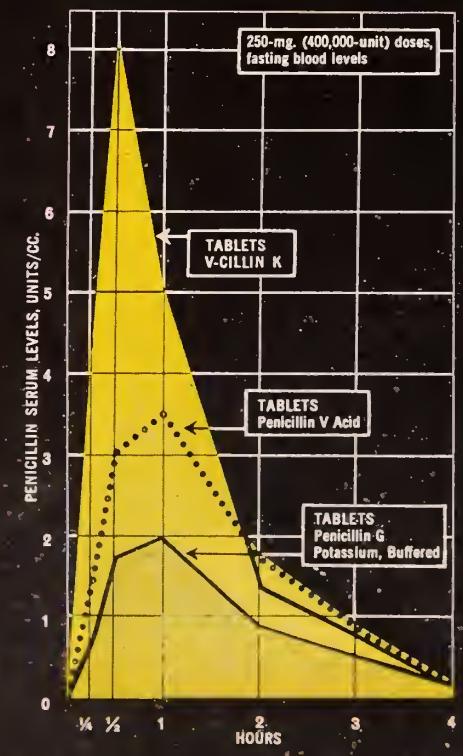
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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Communicating with Patients

So many popular periodicals carry medical stories that we assume that the average reader has a pretty good grasp on medical terms. This, however, is true only of sophisticated and well educated citizens. The millions of adults whose formal education stopped at the 8th or 10th grade are, for the most part unfamiliar with even some fairly simple medical words. For example, Gretchen Collins,* in a survey of persons attending a clinic found that most of them defined "maternity" as a kind of dress and "anemia" as an "enema." In an informal survey by your editor, it appeared that most poorly educated people thought that "concussion" meant a "fractured skull," and that "appendicitis" was so called because you had a "pain in the side." Tell the less knowledgeable patient that you are going to treat his high blood pressure with drugs, and he will assume you mean "dope" (*i.e.* habit forming drugs). We doctors contrast treatment by drugs with treatment by surgery, but to many "drug" suggests "drug addiction." There are still doctors who forget that "hernia" is meaningless to the uneducated. Their term is "rupture" which conjures up an incorrect image of the process. Miss Collins* found out (believe it or not) that 23 per cent of her subjects did not know what part of the egg was the "yolk," and thus dietary instructions about eggs had a good chance of being completely misunderstood. In our own survey, we asked 'What are vitamins'? About one-half of the subjects answered "pills," and did not know, even when asked leading questions, that vitamins are related to food. It is not uncommon for a parent to say "Thank God, the bone is only broken, not fractured;" or, the reverse, "only fractured, not broken." We have a variety of words for convulsions — seizures, paroxysms, and so on. But the average person knows only one word: fits. And the verb which goes with it is always "take" — you don't *have* convulsions or *suffer from* seiz-

*Collins, Gretchen: Journal of the Florida Medical Association, August 1955.

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ures; you take *fits*. The phrase "blood pressure" means *high* blood pressure to many people, so they ask the doctor to "take my high blood pressure." Conversely, when the doctor says something negative or indifferent about blood pressure, the hearer can think only of *high* blood pressure.

Communication here is not too difficult if only the doctor will remember to check on how much of his words get through. Perhaps what we physicians need is a dictionary for the M.D. which will alphabetize the medical words and then define them in basic, sometimes earthy, English.

You and the W.M.A.

We like to boast that ours is the humanitarian calling, the discipline which dispenses its benefits to all regardless of race, creed or political dogma. There can be no "purely American" medicine, just as there can be no "Republican" or "Congregationalist" medicine. If from the laboratories of the Old World comes a drug or process that saves lives, we American physicians will use it. And if out of our work comes a life saving process we want all the world to have access to it. Medicine is thus truly an international activity. And its major international organ is the World Medical Association.

The American Medical Association is a leading member of the W.M.A. Here, in the United States, is located the secretariat of W.M.A. American pharmaceutical and related industries have generously matched the financial support given by American physician-members. Here is an organization which has been a prime mover in the modern restatement of the Oath, which has materially influenced the International Ethical Code, which assists travelling physicians in many ways, which sets up international conferences, which has moved to elevate standards of medical education everywhere, which has helped spread throughout the world the American concept of an unfettered medical profession, which has protected research, guarded many national formularies and pharmacopeias, and won the respect of international labor organizations. Only 10 years old, this federation has already racked up an impressive score.

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EDWARD HENDERSON, M.D.

Montclair

Osteoporosis*

The most prevalent bone disease of the aged is osteoporosis. It is probably a protein not a calcium defect disease. Hence a generous protein diet is recommended. This plus the use of anabolic steroids should materially relieve symptoms even though there will be no roentgenologic evidence of bettered bone structure.

BONE has been described as a hard tissue consisting of an organic matrix of fibers of collagen impregnated with mineral matter, chiefly calcium phosphate and carbonate. The animal matter, or organic matrix, comprises about 33 per cent. The inorganic, or mineral matter, about 67 per cent by weight of bone. Bone is not a static tissue. Its formation and destruction are active and continuous throughout life. Normal stress and strain are necessary for maintaining the integrity of bone.

Albright and Reifenstein [1] first demonstrated that the inorganic or mineral components of bone depend upon the presence and function of the protein matrix. They showed that bone formation consists of two processes: (1) the laying down of a protein matrix by osteoblasts; and (2) the deposition of calcium and phosphate in the protein matrix.

Destruction of bone may result from several quite different causes and factors. There may be direct erosion of bone trabeculae as a result of excessive osteoclastic activity, the outstanding example of which is hyperparathyroidism.[2] A similar process is seen in Paget's disease. For repair of this type of deficiency, sufficient calcium and phosphate must be made available. In avitaminosis D, the absorption of calcium and phosphate from the intestine is impaired. Under these conditions, decalcification develops because sufficient calcium and phosphate are not available for deposition in the newly formed bone matrix. This form of demineralization is found in rickets and osteomalacia. Osteoporosis represents a condition in which the production of the primary bone matrix is insufficient.

Jackson [3] has described osteoporosis as being the "commonest of all diseases." In keeping with this postulate, Gershon-Cohen, Rechtman, Schraer, and Blumberg [4] reported that "an x-ray examination of the spines of healthy residents of a home for old people revealed that 26 per cent had fractures of the vertebrae. All of these had asymptomatic fractures. Not a single history of fracture was elicited in

*Presented at the 191st Annual Meeting of The Medical Society of New Jersey, Atlantic City, on May 1, 1957.

1. Albright, F., and Reifenstein, E. C., Jr.: Parathyroid Glands and Metabolic Bone Disease; Selected Studies, Baltimore, Williams & Wilkins (1948)

2. Snapper, I.: Medical Clinics on Bone Disease, ed. 2, New York, Interscience Publishers (1949) p. 21.

3. Jackson, W. P. U.: Osteoporosis—Commonest of all Diseases? South African M. J., 29:885 (1955)

4. Gershon-Cohen, J., Rechtman, A. M., Schraer, H., and Blumberg, N.: Asymptomatic Fractures in Osteoporotic Spines of the Aged, J.A.M.A., 153:625 (Oct. 17, 1953).

the group and none had been treated for fractures. Osteoporosis with degenerative changes was present in almost all of the 136 patients examined."

Generalized osteoporosis may be caused by:

I. DEFECT IN OSTEOBLASTS

A. Lack of Stress-and-Strain (Atrophy of disuse)

1. Plaster cast or jacket
2. Paraplegia
3. Lying in bed
4. Inactivity

B. Lack of Estrogen

1. Post-menopause

(a) Artificial
(b) Natural

2. Ovarian agenesis (Turner syndrome)

C. Congenital Osteoblastic Deficiency

D. Lack of Vitamin C

II. DEFECT IN PROTEIN MATRIX

A. Insufficient Supply of Protein

1. Protein malnutrition
2. Jejuno-ileal insufficiency†
3. Hyperthyroidism†
4. Diabetes mellitus†

B. Lack of Androgen

1. Eunuchoidism
2. Senility

C. Anti-Anabolic Effect

1. Excess of glucocorticoids

(a) Cushing's syndrome
(b) ACTH or corticosteroid therapy
(c) Alarm reaction†

III. UNKNOWN

A. Acromegaly
B. Idiopathic in young people
C. Biliary Cirrhosis†
D. Rheumatoid Arthritis†
E. Pulmonary Emphysema†

†Osteoporosis is often, but not always found in these condition.

5. Cecil, R. L., and Loeb, R. F.: Textbook of Medicine, ed. 9, Philadelphia, W. B. Saunders (1955) p. 1447.

6. Sante, LeR.: Principles of Roentgenological Interpretation, ed. 9, Ann Arbor, Edwards Brothers (1952) p. 76.

7. Snapper, I.: Osteoporosis, Med. Clin. North America, 36:847 (1952).

Osteoporosis is *not* primarily a disorder of calcium and phosphorus metabolism. It results from a deficiency in the regular formation of the protein matrix of bone by osteoblasts, upon which the mineral components are deposited.

SIGNS AND SYMPTOMS

PAIN is frequently localized to the spine and ribs. The first symptoms are sometimes noted after an accident such as a fall. Usually considerable limitation of movement of the spine and development of kyphosis is a common sign. Often, osteoporotic vertebrae will collapse, radiating pain through the nerve roots of the affected part. Compression fractures of the eleventh and twelfth thoracic and first lumbar vertebrae are most frequent. It follows that radiation of pain to the legs and girdle is observed more frequently than pain in other parts of the body.

DIAGNOSIS

THE chief asset in diagnosing osteoporosis is alertness on the part of the physician. Clinical findings are important since laboratory data are apt to be normal except very early in the disease. Positive diagnosis must depend upon x-ray, but this is not infallible since osteomalacia, osteitis fibrosa cystica or metastatic malignancy may present an identical picture.[5] Another difficulty is that from 30 to 40 per cent of the bone must have been lost before the roentgenologist can be certain of the diagnosis.[6]

This may be due to the fact that destruction begins on the inner bone rather than the cortex. Generalized osteoporosis has a predilection for the spine, ribs and pelvis. Except in the severest of cases, the rest of the skeleton usually shows a normal calcium content.[7] Thus, localization of the demineralization is important.

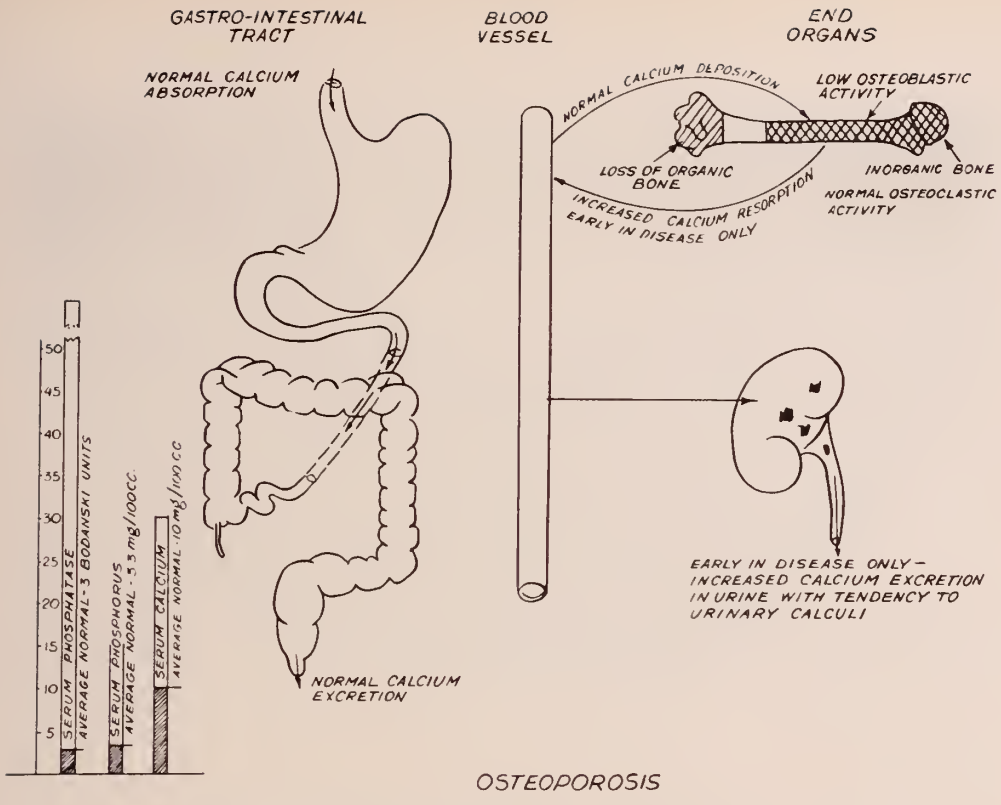


Figure 1. Laboratory findings are generally normal.



Figure 2. Diagrammatic section of normal bone. Note the closely knit compact structure of the cortex.

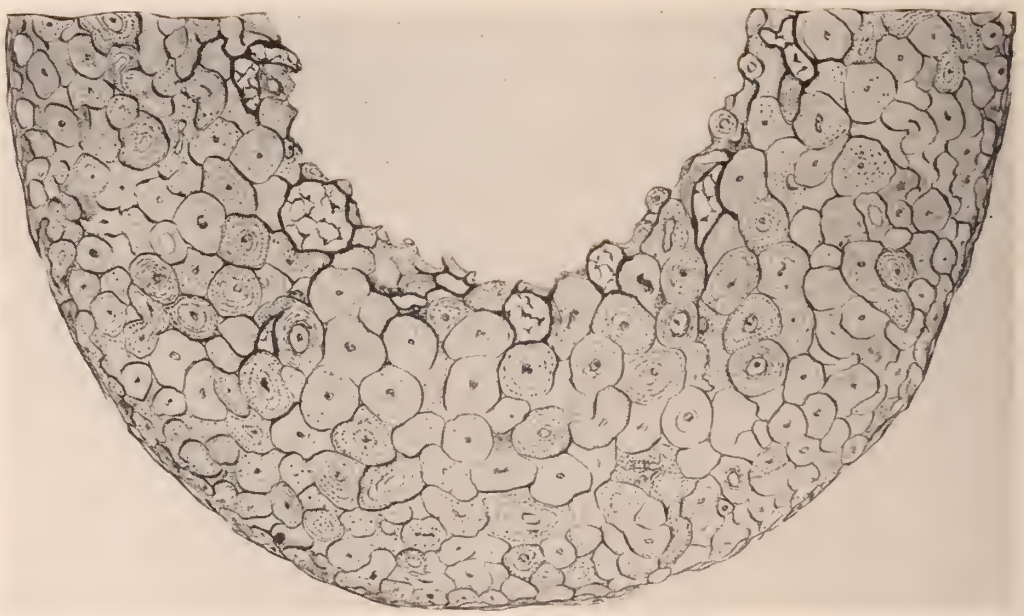


Figure 3. Early osteoporotic lesions. Note that destruction begins on the inner bone.

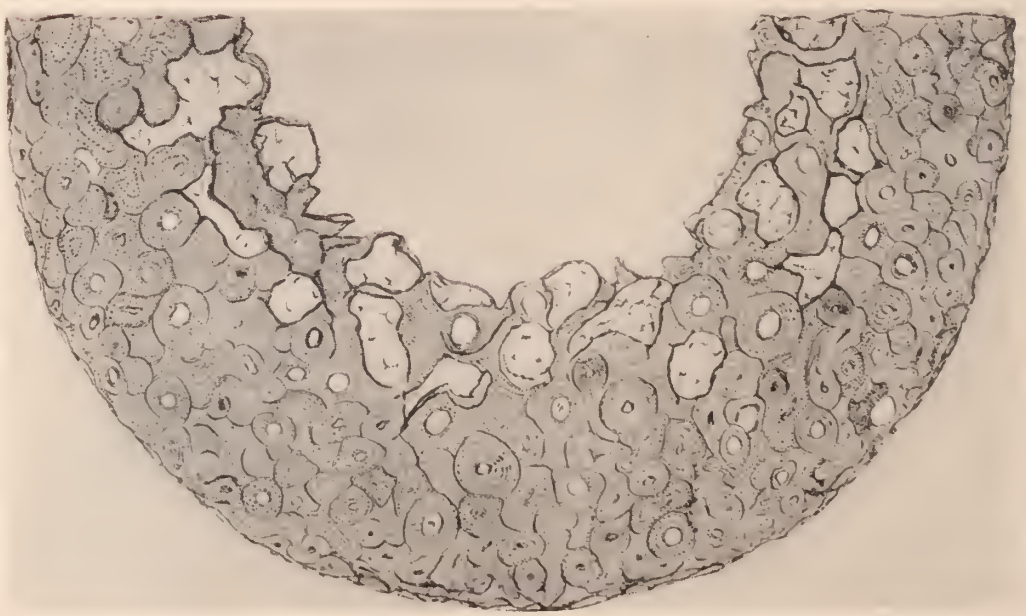


Figure 4. Late osteoporosis showing generalized deterioration of the bone structure.

TREATMENT

TREATMENT is threefold. No one method is likely to be successful without the other two. Since normal stress and strain are necessary to maintain the integrity of bone, activity should be encouraged. Immobilization of any kind, partial or total, should be avoided. Orthopedic procedures when indicated or properly fitted braces often will enable the inactive patient to resume activity.

NUTRITION

THE diet must be adequate. It must have a liberal protein content. Multiple vitamin supplements in normal doses may be helpful. Vitamin C is especially important and should be given in daily doses of no less than 100 milligrams. Supplemental calcium is not necessary. A glass or two of milk a day will provide all of the calcium necessary and will as well provide good protein. Excess fat should be avoided since this tends to limit intestinal absorption of dietary calcium.

HORMONES

SINCE osteoporosis is primarily due to insufficient protein synthesis, treatment with steroid hormones known to have anabolic activity will stimulate the production of new bone matrices. Combination androgen-estrogen therapy has proved to be more satisfactory than either steroid alone.[8] Testosterone propionate is a reliable anabolic agent. It will accelerate protein synthesis, conserve nitrogen and strengthen muscle tone.[7]

In carefully controlled metabolic studies, Knowlton, Kenyon, Sandiford, Lotwin, and Fricker[9] demonstrated that estradiol benzoate is an anabolic agent, equal in potency to testosterone propionate.

Based upon experimental evidence, Snapper[7] concludes that "Estrogen stimulates bone formation and that cessation of estrogen production as seen in the menopause may inhibit bone formation."

Masters and Grody[10] used a combination of 20 milligrams of testosterone propionate plus 1 milligram of estradiol benzoate for the treatment of postmenopausal females and stated: "This combination bestows upon the patient the benefit of each hormone apparently without the burden of any adverse consequences. The chief adversity of estrogen therapy—vaginal bleeding secondary to endometrial hyperplasia—is absent at this balanced dosage level. The amount of androgen clinically effective in combined hormone therapy in the postmenopausal human female is well below the critical level at which its disadvantages, chiefly masculinization, appear." . . . "The systemic anabolic effects of each hormone appear additive, while within the confines of the genital tract the two hormones seem to be in direct opposition."

The rationale[11] for combined androgen-estrogen therapy[12] is well established. Requirements will vary according to individual need. A suggested starting dose is 20 milligrams of testosterone propionate plus 1 milligram of estradiol benzoate dissolved in oil and injected intramuscularly twice weekly. Although perhaps not quite so effective, oral therapy may be substituted if desired. In this case, a combination of 5 milligrams methyltestosterone plus .02 milligrams ethinyl estradiol may be given daily.

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8. Wells, B. B.: Senile Osteoporosis, Am. Prac. & Digest of Treatment, 7:637 (1956).

9. Knowlton, K., Kenyon, A. T., Sandiford, I., Lotwin, G., and Fricker, R.: Comparative Study of Metabolic Effects of Estradiol Benzoate and Testosterone Propionate in Man. J. Clin. Endocrinol., 2:671 (1942).

10. Masters, W. H., and Grody, M. H.: Estrogen-Androgen Substitution Therapy in the Aged Female. Obst. & Gynec., 2:139 (1953).

11. Rechtman, A. M., Yarrow, M. W., and Albert, S. M.: Osteoporosis—A Geriatric Problem, J. Am. Geriatrics Soc., 4:70 (1956).

12. Editorials and Comments: Androgen-Estrogen Therapy for Elderly Patients, J.A.M.A., 163:359 (Feb. 2, 1957).

SUMMARY

Osteoporosis is probably the most prevalent of all bone disease found in old age. The Albright concept that it is a defect of protein metabolism rather than primary calcium loss has now been generally accepted. Almost all women past the menopause will show some degree of osteoporosis and a very large proportion of all men over the age of 60 will show some thinning of the bone structure. The disease may be entirely asymptomatic or it may cause excruciating pain. Positive diagnosis can be made only by x-ray. Treatment is quite satisfactory. A generous protein diet, plus the administration of anabolic steroids will provide prompt relief from pain, although x-ray evidence of improvement in the bone structure may not be evident.

236 Midland Avenue

Radio-isotopes in Brain Tumors

Dr. Sweet* discusses the site of formation of cerebrospinal fluid. While studies with radio-active sodium confirm the classical view that cerebrospinal fluid is formed in the ventricles, the use of "heavy water" resulted in its entry in the cisterna magna *before* its appearance in the ventricular system.

The main part of his testimony* concerned brain tumors. While the brain does not take up radio-active material selectively (as does the thyroid, for example), certain materials are excluded by normal brain which are not excluded by diseased brain. Radio-active arsenic and radio-active copper are taken up by brain tumors. Brain tumors can be diagnosed and localized through the intact skull by the use of radio-isotopes. Currently, about seventy per cent of certain tumors are being correctly diagnosed by this method. The failures are among the relatively inert, slow-growing tumors and in cases where very small tumors cause obstruction and enormous accumulation of cerebrospinal fluid.

Radiophosphates will locate traumatic and hemorrhagic foci in brain.

Boron 10 is taken up by brain tumors and has great affinity for "slow neutrons," which cause its breaking up and releasing energy within a few thousands of a mm. Its use in treatment is currently being developed.

*This is an abstract prepared by Dr. Paul Kolisch of Phillipsburg representing testimony before the Congressional Atomic Energy Committee. This is from testimony by Dr. William H. Sweet of Harvard.

The "Biggest Bargain in History"

"The total cost of illness in terms of medication, medical care, and most importantly, the loss of time and income to the sufferer and his family, has been so sharply reduced as to make any comparison with past years almost ridiculous. Modern medical care is the biggest bargain in history," So said John A. MacCartney to the Pharmaceutical Advertising Club.

MacCartney added that if the cost-per-dose is the only criterion used, then the treatment our forefathers received was far cheaper than is the case today.

"But," he explained, "if we compare the end result of modern medicines with those of the past, we find a startling and happy reversal of the situation."

MacCartney, who as president of the American Pharmaceutical Association is head of the nation's 30,000 pharmacists, also commented on pharmaceutical manufacturing.

"It is the only industry in the world which is furiously engaged in a continuous effort to work itself out of business," he said.

"By this, of course, is meant that the astonishing progress we have made in the control of many diseases has made it possible to discontinue production of remedies formerly used."

MacCartney explained that as one serious disease is eliminated, the average person's life is prolonged to the extent that he is a "statistical probability for some other disease."

"We are in the anomalous position of being cured of one disease so we can live long enough to acquire another," he added.

Edward Kessler, M.D.

Morristown

The Causes, Prevention and Management of Hyponatremia*

All but the youngest physicians will realize that electrolyte metabolism was a much neglected subject in their medical school days. Here is a welcome, compact rundown of one aspect of this topic.

The availability and widespread use of the flame photometer has uncovered numerous abberations in sodium metabolism. Most commonly observed in clinical circumstances is hyponatremia. Hyponatremia is a depression of the serum sodium concentration below 135 milli-equivalents per liter.

Does hyponatremia presuppose the existence of the "low-salt syndrome?" To be sure the "low-salt syndrome," which implies depletion of body sodium, is associated with hyponatremia, but hyponatremia may be seen in a variety of states where the "low-salt syndrome" is not present. Recognition of this is important, because of its therapeutic implications.

Physiology of Sodium Homeostasis

The normal 70 kilogram male contains approximately 3000 milli-equivalents (69 Grams) of sodium, of which about two-thirds reside outside the tissue cells. The remainder is distributed intracellularly in the order of around 10 milli-equivalents per kilogram of tissue, and in bone where it exists in both a freely exchangeable and a bound form.

Basically sodium homeostasis is maintained by compensatory alterations involving (1) tonicity of the body fluids, (2) the volume of the extracellular fluid, (3) the internal redistribution of sodium, and (4) renal hemodynamics.

Tonicity of the Body Fluids: Verney[1] demonstrated that hypertonic solutions injected into the carotid arteries of dogs evoked an antidiuretic response. An acute reduction in tonicity (as exemplified by a large water intake) leads to a brisk water diuresis. These alterations in response to changes in tonicity are produced by variations in the secretion of antidiuretic hormone by the posterior pituitary *via* an intact supra-opticohypophyseal system. An increase or a decrease in the concentration of sodium in the serum of only two milli-equivalents per liter is sufficient to evoke antidiuresis or diuresis, respectively. Thus, the concentration of sodium in the serum is maintained normally within narrow limits.

Extracellular Fluid Volume: Under many circumstances the body will guard its fluid volume even at the expense of sodium concentration. Variations in extracellular fluid volume will produce changes in water and sodium excretion; and these changes may be independent of one another. This is to be expected

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1. Verney, E. B.: Proc. Roy. Soc., London, s. B, 135:25 (1947).

since the excretion of water is under the control of the posterior pituitary, while the excretion of sodium is controlled largely by adrenal cortical activity.

WHEN pitressin tannate in oil is given for several days while maintaining a high fluid intake, serum sodium concentration falls as a result of dilution concomitant with an increase in urine sodium excretion.[2] Expansion of plasma volume by albumin infusion is attended by an increase in urine flow and either no change or a fall in sodium excretion.[3,4] Hypotonic expansion of the extracellular space produces an increase in sodium excretion;[5] whereas contraction of the extracellular space, as during dehydration, is associated with a sharp decline in sodium excretion even though the serum sodium concentration may rise as high as 190 milli-equivalents per liter.[6] These various observations demonstrate not only the independence of extracellular volume and tonicity, they also demonstrate that water and sodium excretion may proceed independently with respect to alterations in extracellular volume.

The discovery of aldosterone in the urine of many patients with fluid retention, and the demonstration of this hormone in adrenal venous blood render it likely that this is the prime hormone controlling the excretion of sodium and potassium. The stimulus for its secretion is not entirely clear, some[7] ascribing secretion to an elevated serum potassium level and others[8] relating it to sodium intake. Bartter's group,[9] however, believe that aldosterone secretion is regulated by extracellular volume independently of the serum potassium or sodium concentration. According to their view, expansion of extracellular volume decreased, while contraction of extracellular volume increased aldosterone secretion. The aldosterone acted primarily on the renal tubules altering the reabsorption of sodium. Why aldosterone secretion is increased in edema states remains obscure, although an explanatory hypothesis has been offered.[9]

Internal Redistribution of Sodium: In addition to the effects on renal tubular reabsorption of sodium the adrenal cortex plays an important part in the distribution of sodium within the body. In uncontrolled Addison's disease intracellular sodium is lost, and potassium is gained[10] a phenomenon reversed by the administration of adrenal cortical extract or desoxycorticosterone. Animals and humans under the influence of ACTH or cortisone exhibit shifts of sodium from one portion of the body to another. Thus, in dogs, muscle sodium may increase while the sodium content of other tissues falls.[11] In humans, erythrocyte sodium may rise as a result of transfers from other areas of the body.[12] In general these exchanges appear to be linked with the energy derived from the metabolic activity of the cells; and sodium transport in most instances moves in a direction opposite to potassium. The mechanism whereby adrenal cortical activity influences sodium and potassium transport remains to be elucidated. Whether aldosterone is implicated in these transfers has not been established.

Renal Hemodynamics: It is easy to visualize changes in the amount of sodium delivered to the renal tubules as the glomerular filtration rate changes. If the glomerular filtration rate declines, *a priori*, the amount of sodium delivered to the renal tubules per unit time

2. Leaf, A., Bartter, F. C., Santos, R. F. and Wrong, O.: J. Clin. Invest., 32:868 (1953).

3. Welt, L. G. and Orloff, J.: J. Clin. Invest., 30:751 (1950).

4. Petersdorf, R. G. and Welt, L. G.: J. Clin. Invest., 32:283 (1953).

5. Strauss, M. B., Davis, R. K., Rosenbaum, J. D. and Rossmeisl, E. C.: J. Clin. Invest., 31:80 (1952).

6. Winkler, A. W., Danowski, T. S., Elkinton, J. R. and Peters, J. P.: J. Clin. Invest., 23:807 (1944).

7. Laragh, J. H. and Stoerk, H. C.: J. Clin. Invest., 36:383 (1957).

8. Mulrow, P. J., Lieberman, A. H., Johnson, B. B. and Luetscher, J. A., Jr.: J. Clin. Invest., 35:726 (1956).

9. Bartter, F. C., Liddle, G. W., Duncan, L. E. Barber, J. K. and Delea, C.: J. Clin. Invest., 35:1306 (1956).

10. Swingle, W. W. and Remington, J. W.: Physiol. Rev., 24:89 (1944).

11. Overman, R. R., Davis, A. K. and Bass, A. C.: Amer. J. Physiol., 167:333 (1951).

12. Kessler, E., Nelson, S. S., Elder, N. R., Rosano, C. L. and Nelson, W. P., III: J. App. Physiol., 10:93 (1957).

must also decline. All other things remaining equal, if the normal 99 per cent of filtered sodium is reabsorbed, less sodium will appear in the urine. Conversely, if the glomerular filtration rate increases, more sodium will be delivered to the tubules per unit time, and thus more sodium will appear in the urine. On the other hand if renal plasma flow changes without a change in glomerular filtration rate, the filtration fraction (GFR/RPF) varies, but the amount of sodium delivered for tubular reabsorption remains the same. In addition to nervous influences, a function of plasma sodium concentration has been considered recently to influence also the glomerular filtration rate.[13]

MANAGEMENT OF HYPONATREMIA

In this discussion of sodium homeostasis, the factors governing sodium metabolism have been separated. However, such separation in clinical practice, is seldom simple. An attempt at differentiation is of great importance to pursue intelligently the management of the hyponatremic patient. Frequently in the hyponatremic patient multiple forces have been at play. This is readily apparent in the edematous cardiac, nephrotic or cirrhotic, who has been given frequent mercurial diuretics or ion exchange resins while on a low sodium diet, and who may require thoracenteses or paracenteses. These procedures suggest he has been sodium depleted, while the persistence of edema suggests he is avidly retaining water. Here the effects of excessive sodium loss and body fluid dilution have combined to produce hyponatremia. If he is also malnourished (as is frequently the case) shifts of sodium intracellularly, may further complicate the picture. Glomerular filtration is often reduced. In such a complex situation the presence of symptoms of sodium depletion must be evaluated carefully. The more important symptoms are weakness, apathy, muscle cramps, absence of thirst, hypotension, oliguria and azotemia. When it is determined that the symptoms are the result of sodium depletion ("low-salt syndrome") the use of hypertonic saline is justified. No more than 10 Grams of sodium chloride as a 3 or 5 per cent solution should be given in a twenty-four hour period. Marked and rapid increases in tonicity of the plasma produce a sensation of thirst and lead to water drinking defeating the purpose of the hypertonic saline. Therefore, the infusion should be given slowly, and water intake must be restricted rigidly for 24 to 48 hours after hypertonic saline infusions. In milder cases salt given by mouth is valuable.

In the absence of symptoms of sodium depletion, hypertonic infusions are best avoided. Many patients with hyponatremia are perfectly comfortable with serum sodium concentrations as low as 125 milli-equivalents per liter. In fact, their total body sodium content may be increased. Below this level, body physiology may be further compromised because of greater impairment of renal hemodynamics. Hypertonic saline in this particular circumstance produces rises in serum sodium concentration which are poorly sustained and of smaller magnitude than would be expected from the amount given. Moreover, it increases thirst, water intake, and ultimately more edema develops. When dilution of body fluids is the primary factor inducing hyponatremia, fluid intake must be restricted. In addition to dilution, exchange of sodium for intracellular potassium may play a role in the hyponatremic condition. Treatment of this event with potassium chloride in doses ranging from 4 to 22 Grams daily has been attended by more marked and more sustained rises in serum sodium concentration than with sodium administration.[14] Potassium therapy, however, should be pursued with caution when hyperkalemia is present, unless the potassium is administered orally and urine volume is adequate.

Certain conditions as chronic adrenal insufficiency, salt-losing nephritis and diabetic acidosis are characterized by extensive renal losses of sodium. In all three conditions the mechanism of sodium wasting is different. In chronic adrenal insufficiency the hormone acting on the renal tubules to stimulate sodium reabsorption is lacking. In salt-losing nephritis

13. Blake, W. D.: J. Clin. Invest., 35:691 (1956).
14. Laragh, J. H.: J. Clin. Invest., 33:807 (1954).

the target organ (the renal tubules) is defective and cannot respond to adrenal stimulation. In diabetic acidosis sodium losses result from osmotic diuresis associated with glycosuria and from excretion in combination with keto-acids. Moreover, in diabetic acidosis sodium shifts into the cells. Although salt-losing nephritis is extremely rare, when seen, it is easily confused with adrenal insufficiency. In the severe case differentiation is possible by performing a total eosinophil count. In the former condition, since adrenal function is normal, the count should be close to zero, or at the most twenty per cubic centimeter. If above this level adrenal insufficiency cannot be ruled out. The administration of hydrocortisone, 100 milligrams intravenously, or aqueous adrenal extract, 50 milliliters intravenously, will produce striking improvement within an hour (at times within minutes) in severe adrenal insufficiency. In the meantime, since these patients are also dehydrated, as a result of osmotic diuresis, normal rather than hypertonic saline should be given in amounts up to four liters per day. The development of a positive sodium balance is very important. Of course the adrenal hormones will quickly aid in restoring sodium balance in the addisonian, but the patient with salt-losing nephritis does not respond to adrenal hormones and, moreover, may require 12 to 20 Grams or more of salt daily to maintain equilibrium.[15] In diabetic acidosis, normal saline is chosen because of concomitant dehydration. As acidosis is corrected the serum sodium may rise to more than can be explained by the amount infused, suggesting a release of sodium from the cells as recovery ensues.

A peculiar type of salt wasting has been reported in patients with pulmonary disorders as tuberculosis, carcinoma, emphysema, and mediastinal tumors. These patients are noteworthy for the absence of symptoms referrable to hyponatremia.[16] Most of these patients are markedly malnourished. Patients with pulmonary emphysema do not respond to small doses of desoxycorticosterone acetate, but do respond to large doses. When the emphysema was treated vigorously and the malnutrition was corrected, the salt wasting ceased.[17] This form of hyponatremia is probably related to the hyponatremia frequently encountered in the malnutrition of other chronic illnesses. Two patients with mediastinal tumors showed evidence of increased secretion of antidiuretic hormone.[18] "Pulmonary salt wasting" may be differentiated from adrenal involvement due to tuberculosis or carcinoma by the eosinopenic response to ACTH.

THE surgical patient or the patient subjected to other types of major trauma exhibits sharp increases in adrenal cortical activity, proved by elevated blood levels of 17-hydroxy-corticoids and eosinopenia. In addition an antidiuretic effect is noted for 24 to 72 hours after surgery.[19] When gastric suction is employed following surgery fluid and salt losses daily may range as high as five liters and thirty Grams, respectively. Additional losses of water and salt (up to four Grams daily) may be lost in perspiration and from the respiratory tract.[20] Lack of consideration for these factors may lead to hyponatremia in the following ways. First, zealous administration of water during the antidiuretic phase leads to dilution of body sodium. Second, inadequate administration of fluid and salt after the antidiuretic phase leads to dehydration and frequently hyponatremia because of continued extrarenal losses and/or the presence of pathologic renal losses. Finally, during stress sodium may exchange for intracellular potassium, an exchange which is partially prevented by the administration of potassium.

The management of hyponatremia in the surgical patient is largely preventive. Sufficient

15. Murphy, R. V., Coffman, E. W., Pringle, B. H. and Iseri, L. T.: Arch. Int. Med., 90:750 (1953).

16. Sims, E. A. H., Welt, L. G., Orloff, J. and Needham, J. W.: J. Clin. Invest., 29:1545 (1950).

17. Nelson, W. P., III: Personal communication to the author.

18. Schwartz, W. B., Bennett, W., Gurelop, S. and Bartter, F. C.: J. Clin. Invest., 35:734 (1956).

19. Moore, F. D.: J. Amer. Med. Assn., 154:379 (1954).

20. Elkinton, J. R. and Danowski, T. S.: The Body Fluids, Williams and Wilkins Co., Baltimore, 626 pp. (1955).

water and salt should be given pre-operatively to balance losses by all routes. Postoperatively, during the antidiuretic phase, when adrenal cortical activity is high, little salt is needed if intubation is not employed; and water should be given in amounts only necessary to cover losses. When gastro-intestinal suction is used an idea of the amount of sodium required for replacement can be obtained by measuring the sodium content of the aspirate. If hyponatremia develops normal saline is used unless symptoms of salt depletion are present. A significant correction of the hyponatremic state occurs because sodium shifts from the cells to the extracellular space. The rise in serum sodium concentration is usually much greater than can be explained by the amount of salt present in the normal saline. Potassium will not effectively induce a transfer of sodium out of the cells in the subject who is salt depleted, as these patients usually are. Potassium therapy may be indicated, however, because of concomitant potassium depletion.

THE origin of hyponatremia in chronic renal insufficiency appears to vary with the degree of renal involvement. In the early stages polyuria frequently occurs, and tubular reabsorption of sodium is impaired. An explanation for the defective sodium reabsorption, which has anatomic support, is based on the fact that fewer functioning tubules are available. If the glomerular filtration rate does not change, more sodium is delivered to these tubules. The increased amount of sodium initiates an osmotic diuresis and as much as 15 to 20 per cent of the filtered sodium may be excreted instead of the normal one per cent.[21] Salt-losing nephritis may be regarded as an exaggeration of this phenomenon. When, as is commonly done if hypertension is present, sodium intake is restricted, sodium depletion may ensue, and hyponatremia may develop. To prevent this it is necessary to administer sodium, as chloride or in part as bicarbonate, if acidosis is present, in order to maintain sodium balance.

As renal failure progresses, the development of cardiac failure may limit the use of sodium. In this phase polyuria may be supplanted by oliguria. Water intake is now restricted to the sum of the urine output and insensible fluid loss (40 milliliters per hour). If greater amounts of water are given to "wash out" non-protein nitrogen dilution hyponatremia may result.

In the terminal phases of chronic renal insufficiency hyponatremia may develop in the absence of edema or cardiac failure, and it cannot be explained by deficient sodium intake or excessive urinary losses. An elevated serum potassium concentration suggests potassium has left the cells and sodium has entered. Treatment at this point is singularly unrewarding. Large amounts of glucose may drive potassium into cells and sodium out. This, at best, is transitory. Resins exchanging sodium or hydrogen for potassium may be helpful, but these are not generally available.

In acute renal failure hyponatremia develops during the anuric phase in a similar manner to chronic renal insufficiency. In addition to dilution and cellular exchanges, sodium is often lost *via* extrarenal routes. Management is simpler because basically acute renal failure is self-limited, and the patient recovers function, if he can be kept alive. Sodium should be replaced only when there is vomiting, diarrhea or profuse sweating. Commonly excessive amounts of water are administered and contribute to hyponatremia. This usually occurs because the water liberated by the metabolic processes is not considered. Water of oxidation amounts to about 300 milliliters daily, and a sizeable excess of fluid is thus administered when only the urine output and insensible loss are considered. Water of oxidation should be subtracted from water lost by other routes in estimating the amount necessary for replacement. During the anuric phase potassium exchange resins are extremely valuable both to replace lost sodium and to remove potassium. Concentrated glucose infusions with small amounts of insulin (10 to 20 units) may drive potassium into the cells and bring sodium out. During the diuretic phase the urine excreted is virtually isotonic, and large amounts of sodium may be required to

21. Merrill, J. P.: Metab., 5:419 (1956).

prevent hyponatremia. As recovery progresses the ability to reabsorb sodium in the renal tubules improves, and the need for sodium decreases.

SUMMARY

AN ATTEMPT has been made to express basic concepts of sodium metabolism and to evolve an approach, based on these concepts, to the prevention and therapy of hyponatremia in various diseases. The physiology of sodium metabolism has not been discussed fully, and the list of diseases discussed is incomplete. This has been a matter of design. The interested reader may cull additional references from the bibliography. The views expressed are those currently held, and may be challenged as further knowledge of electrolyte metabolism accumulates.

All Souls Hospital

Hinged Finger Joints

A stainless steel hinge, for badly damaged finger joints, that works without pain and improves the appearance of the injured hand is now in use. Good results in 10 cases were reported by Lt. Col. Earl W. Brannon, U. S. Air Force Hospital, Lackland Air Force Base, San Antonio. The device is designed to prevent the unwanted rotation and instability that are common faults of other types of finger joint replacements.—*International Record of Medicine,* February, 1957.

A Return to Lister?

Surgeons and hospital operating teams must return to the old-fashioned scrub-up principles of Lister to combat a rising incidence of postoperative infections caused partially by overdependence on antibiotics.*

Other factors named by the panel as contributing to the increasing number of infections in hospitals are the development of bacterial strains resistant to antibiotics, increased hospital utilization, longer operations and older patients.

One panellist said: "Up to the time antibiotics were introduced in surgery, the good surgeons with low infection rates took care of themselves and watched their house officers scrub and told them to go back and scrub some more if they didn't like the way they did it. If we would return to this sort of thing, I think we would see a fair reduction."

He added that to reduce infections now, hospital personnel must return to using the "same precautions their predecessors did in the same situation; they should return to the principles of Lister."

Dr. Howe observed: "Prophylactic use of antibiotics subtly tends to cause a deterioration in surgical technic. Even if we used good technic, there are going to be some infections, and then the total hospital environment comes into it. Thus in some hospitals, staphylococcus infections have decreased while other bacterial infections, such as the gram-negative bacteria found in the intestines, have been causing more infections."

Dr. Lepper attributed "some of the trouble to medical and surgical procedures which in 1940 we wouldn't have thought of doing. A lot of the procedures were devised because of relative control of virulent organisms. Much of what we used to attribute to the highly virulent organisms was due to failure to isolate the causative organisms."

*From the June 16, 1957 issue of *Hospitals,* Journal of the American Hospital Association. The panellists were Doctors M. H. Lepper, C. W. Howe, Sidney Liswood and Sarah Hardwicke.

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Cancer Advances

CERVICAL CYTOLOGY AS AN AID IN CANCER DETECTION

Second of a series prepared by the Cancer Control Committee of The Medical Society of New Jersey.

The phrase cancer "detection" rather than cancer "diagnosis" is used here to impress upon the physician's mind the fully justified concept that when it comes to the diagnosis of carcinoma of the cervix uteri, the most accurate diagnostic method is the histologic evaluation of a cervical biopsy.

Papanicolaou first described, in 1928, the finding of cancer cells in vaginal secretions of human subjects suffering from this disease. In the ensuing years, many workers have devoted considerable time to cervical cytology. Surveys have been conducted of the female population of entire communities under the auspices of the United States Public Health Service. Some universities have established cytologic laboratories wholly devoted to this discipline. Enormous numbers of negative cytologic studies must be done to detect one positive case of carcinoma of the cervix in the general population. Thus, the money cost to the public for the detection of a single case of cancer of the cervix by cytologic survey methods becomes prohibitive. This is a little publicized aspect of cervical cytology.

Carcinoma of the cervix uteri is most frequently seen in the decade of 45 to 55 age bracket. There is, however, much disagreement among the histopathologists as to what constitutes the early histologic lesion of cervical carcinoma. It is to this group of pre-invasive neoplastic changes of the cervix to which the term carcinoma *in situ* has been applied in a broad sense. These investigators feel that if one studies the histologic changes in the uterine cervix in the 35 to 45-year decade, frequently these pre-invasive histologic changes, so-called carcinoma *in situ*, can be observed. While it is not conclusively proved, it is believed by many that these are the cases which eventuate in carcinoma of the uterine cervix in the 45 to 55 age bracket as a non-controversial histologic diagnosis.

Carcinoma of the uterine cervix has been identified in female children and young adult females. These represent the unusual rather than the average. Carcinoma of the uterine cervix is known to arise primarily at the squamocolumnar junction of the endocervical tissue. These cells *do* exfoliate. Cervical cytologic studies, therefore, when applied as a detection method to patients in the 35 to 45 decade, would appear to be the field of its greatest utility. It has been shown that this discipline will detect exfoliated malignant cells when the histologic biopsy shows the lesions designated as carcinoma *in situ*, and at a time when inspection of the cervix may show no appreciable lesion. Cervical cytology as a cancer detection method has absolutely no applicability when the physician is dealing with a female patient in the cancer decade who shows, on inspection of the cervix, an appreciable, and (to the experienced physician) an unquestionable neoplastic lesion. Cases of this type necessitate but one diagnostic technic: surgical biopsy.

Technically, the preparation of a cervical smear is a relatively simple procedure, requiring only adequate exposure of the cervix with a vaginal speculum; fixation of the cervix, preferably with a Babcock forceps; and the scraping of the external os with an ordinary tongue blade or commercial wooden blade. The

abraded material is then spread evenly over the surface of a clean glass slide. Duplicate slides should always be prepared. It was taught at one time that these slides should be immediately fixed in equal parts of ether and alcohol. Some still adhere to this. Others feel that the slide may be permitted to dry in the air, and that fixation in ether and alcohol may be delayed for sixty minutes or longer. Some workers cover the smears with glycerol. After application of a second slide, such preparation may be mailed to a competent pathologist for study.

Papanicolaou has provided us with a useful classification of cervical smears:

Grade I: Absence of atypical or abnormal cells.
Grade II: Atypical cytology, but no evidence of malignancy.
Grade III: Cytology suggestive of, but not conclusive of malignancy.
Grade IV: Cytology strongly suggestive of malignancy.
Grade V: Cytology conclusive for malignancy.

This classification has stood the test of time. In our laboratory, Grade IV classifications have been productive of surgical biopsies which showed undisputable carcinoma of the cervix.

Falsely positive smears may be due to inexperience on the part of the cytologist. However, the lesion designated as squamous metaplasia of the endocervical glands may account for a high number of false positive readings. To date, this is not recognized as a precursor of squamous cell carcinoma of the cervix.

Many color atlases have been published portraying the normal and abnormal features of cervical cytology. The pathologist should be familiar with the appearance of squamous epithelial cells from the superficial layers of the cervix, the oval cells from the deeper layers of the cervical epithelium, the rounded cells which may be exfoliated from the endometrium, and the hemorrhagic menstrual smear. To this, one must add familiarity with the normal postmenopausal cervical cytology and a judicious amount of caution when dealing with smears from the cervix of a pregnant female. Chronic endocervicitis produces a smear showing red blood cells, polymorphonuclears, and normal-appearing squamous epithelial cells. Most competent students of cervical cytology will recognize such smears and readily identify them as due to chronic endocervicitis.

Malignant cells have been identified by pathologists for a longer period of time than has been devoted to the popularization of cytologic diagnostic methods. The criteria of malignant cells has not changed, these are:

1. Hyperchromasia.
2. Altered nuclear-cytoplasmic ratio.
3. Altered nuclear-nucleolar ratio.
4. Atypical mitotic figures.

These criteria of neoplastic cells are as applicable to the diagnosis of malignant cells in a cervical smear preparation as they are to histologic section. Regenerating cells may give an identical picture. The poorly trained observer may misdiagnose such preparations. Because of this, the most expert smear interpretation is usually given by the pathologist. He can readily check his smear interpretation with a confirming biopsy.

Advocates of this discipline have recently used this to follow-up radiation therapy of cervical carcinoma. Claims have been advanced that the cytologic changes will serve as an index of the efficacy of radiation therapy for this disease. This requires further investigation.

Cervical cytologic studies are of value in the early diagnosis of cancer of this organ. This technic deserves wider application to females in the 35 to 45 year age group who present themselves to physicians with gynecologic complaints. We are not convinced of the desirability of reading slides without some knowledge of the clinical history. We therefore question the desirability of using the services of technicians trained as slide scanners.

The members of the New Jersey Society of Clinical Pathologists agreed, many years ago, to read cervical smears from indigent patients without charge to the referring physician. The utility of the method when applied under appropriate circumstances is eminently satisfactory for the early detection of cancer of the cervix. Cytologic methods cannot displace a surgical biopsy as an aid in cancer detection and therapy.

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Englewood

Some Social-Psychiatric Aspects of Pregnancy and Childbearing

The rising tide of wonder drugs obscures the fact that medicine is, after all, a kind of social science. In this unique study, Dr. and Mrs. Gordon highlight the role of such social factors as religious differences, position in the social scale, suburban living, and husband's being at home or away from it. It reminds us that there is more to medicine than medicines.

In a recent article[2] we reviewed some of the literature concerning emotional disorders of pregnancy and childbearing. In the present paper we present some of our studies regarding social and cultural factors: the family, including personal and social histories of the patients we have observed.

We have tried to use only objective historical data, such as could be obtained by a questionnaire or simple interview, rather than psychoanalytic or psychodynamic information that would require projective tests and specially trained interviewers. There is interaction between the maternity patient's life history and her inner psychodynamics. Much can be learned about her emotional state from information about her social history.

We have tried to determine which items suggest emotional strains and potential inner conflicts. Thus we obtained data about incidence of broken homes and emotional illness in the family. These would suggest constitutional susceptibilities as well as potential childhood conflicts and early emotional traumata.

Previous personal history of emotional disorder would indicate a proneness to later difficulties. Severe physical illnesses, particularly associated with pregnancies, would seem likely to be correlated with development of fear and anxiety. We obtained indications of potential marital conflict from information about religious intermarriage and age disparity. Depreciation in social status might suggest financial and social strains. Moving from urban residence to the suburbs would involve the difficulties of making new adjustments, friends, and developing new interests.

Conflicts with parents and authority might be related to considerable age disparity between the patient and her parents. Similarly, conflict with the role of motherhood might be greater if the patient herself is older or has an unplanned or female child.

Acute strains and tendency to overload herself might be associated with changing residence during pregnancy, with husband's being away from home, and with her failing to ob-

We express our appreciation to Dr. Paul Eiser, Dr. Abraham Jacobs and Dr. Adella Youtz of Columbia University; to Dr. Ralph Crowley of the William A. White Institute for their suggestions, and to Dr. Henry D'Agostin and the obstetrical nursing and administrative staff at the Englewood Hospital for their assistance in this research.

tain help from experienced women when returning from the hospital with her baby.

We speculated that women whose lives involved numbers of these strainful experiences might have "neurotic" tendencies. A life history of multiple indications of potential conflict might suggest potential emotional disorder. In our study we explored this and tried to identify the features in the social history that were more important in the emotional disorders of pregnancy and childbearing.

PROCEDURE

We have obtained objective personal data from 56 private out-patients with emotional disorders arising during pregnancy and until three months after delivery. We compared this with similar data from interviews with 118 private patients who were delivered of normal infants at the Englewood Hospital. We included 87 emotionally disturbed young married women referred for private out-patient psychiatric examination and care, unassociated with pregnancy or childbirth.

FINDINGS

Emotionally ill persons usually give a history of previous emotional disorders in their families and their own lives. Our patients of both emotionally ill groups also gave a history of more physical illness, hospitalizations and operations than did controls. In addition, the emotionally ill maternity group, particularly, had suffered physical complications of their pregnancies. There is evidence that tendency to miscarriages and toxemia, is inter-related with emotional and social factors.

Three complications are now receiving more general attention than before. They are: religious intermarriages,[1,6] age disparity between husband and wife,[2] and social or economic mobility.[7] We have findings which indicate that intermarriage places a particular burden upon the wife and is disproportionately associated with emotional disorders in women of all ages. On the other hand in our married *male* psychiatric patients, the incidence of intermarriage is no greater than in our control group.

In previous generations, age differences between husband and wife were much more prevalent than in the present childbearing group, as measured by the ages of the parents of our controls. A husband four or more years older or younger than his wife is now the exception. Greatly differing ages in this era of less wifely subordination may indicate potential conflict.

Our Bergen County patients, as a rule, were "rising" from working class immigrant forebears into the middle class in response to American cultural tradition. This is not without strain. The husband works longer hours to "get ahead," thereby becoming less available to his wife and children. Also, the wife has difficulty adjusting to other women who have started from a point higher on the ladder than she, and who are not readily accepting of her.

The strains of suburban migration are apparently reflected more in the maternity group. Interstate and international migration[4] are associated with greater incidence of psychoses.[5] There is little mention in the literature of the higher incidence of migration specifically in the childbearing group that we have observed.

Our obstetrical-psychiatric patients had almost double the proportion of older parents than the controls, and slightly more than the emotionally disturbed non-pregnant women.

An important factor we have noted in our analysis is the significance of strains at the time of childbearing: changing homes, absence of husband, and no additional assistance. Most "normals" remain in their same residence throughout the pregnancy and for at least six months after the delivery. They enlist the aid, not only of husband and friends, but of mother, mother-in-law, a baby nurse, sister, or other relatives (in that order of decreasing frequency, according to our data). Their husbands often take vacations from work for a week or so. Rarely do they leave on a business trip. In military medicine the importance of the husband's presence is well recognized. Only in dire emergency is the husband denied a leave to be with his wife during this period.

In India, it is the custom for native women to return to their mothers to have their babies. If nothing else, we can recommend from our study that women try to avoid moving their residence, that they get help from an experienced female relative or nurse, that they have their husbands available during the childbearing period. Many of our patients, in advanced psychotic depressions, recovered when we arranged for the women of the family or a nurse to come to the rescue.

Unplanned and female children were more often associated with emotional disturbances of childbearing. Some of our patients have difficulty in identifying with or accepting the basic function of the feminine role. It is not surprising that they receive more of a shock on delivering a female than a male child. Moreover, there is still a tendency among both husbands and wives to value a "son and heir" more than a daughter. This preference may be denied—but it is often there.

A PSYCHIATRIC-OBSTETRICAL SYNDROME?

ARE the emotional disorders of pregnancy and childbearing [8] different from other neuroses and psychoses? Our findings reflect certain common features in the background histories of emotional disorders of married women generally. But certain significant features are more prevalent in our Bergen County obstetrical-psychiatric group. They give a background history of greater incidence of (a) previous emotional disorder, and (b) older parents. They have undergone (c) more physical complications of pregnancy. They have more frequently (d) recently migrated to the suburbs. Acute strains include more reports of (e) an unplanned pregnancy, (f) a recent change of residence, (g) the husband being away, (h) birth of a female child, and (i) no outside help in the first weeks at home.

Our evidence suggests that certain emotionally labile women are made sensitive to pregnancy by specified recurring background events. In pregnancy and childbearing they are subjected to greater amounts of definitely identifiable strains associated with assumption of a new role and new responsibilities.

PREDICTION OF EMOTIONAL COMPLICATIONS

FOR each patient in each of the two obstetrical groups we checked the background factors that pointed toward emotional strain and totaled the checks, thus giving each patient a score. We divided our 56 emotionally ill maternity patients into mild, moderate, and severe disorders. Our criteria were:

Mild—responded successfully to 15 or fewer sessions of psychotherapy alone.

Moderate—required more than 15 sessions, but generally improved or recovered with psychotherapy and physiologic treatment.

Severe—required hospitalization and physiologic treatments immediately, and often became long term problems.

We found that 80 per cent of the *controls* had scores of four or less on the pertinent background historical items. Of the *mild* emotional disorders, 70 per cent had scores of five to seven, the remainder were less than five. Of the moderately ill, 65 per cent had scores from seven to ten pertinent items. Of the severely ill, 90 per cent had scores of ten or greater.

It appears there may be some predictive power to pertinent social psychiatric historical data of this nature in the obstetrical group. This may prove of some mental health value in guarding against development of this disorder, as well as in the difficult problem of therapeutic abortion and sterilization. But nothing final can be said without additional studies.

SIGNIFICANCE OF THIS STUDY

THIS type of study does not prove any definite cause and effect relationship. Certain objective historical facts are often associated with emotional disorders of childbearing. This may permit prediction of emotional disorder from pertinent historical information with some degree of accuracy. Our data suggest further studies.

A single item by itself is not related to emotional disorder; but taken together, many such items are. Moreover, total numbers of strains seem to be associated with severity of illness. Some background factors may be more important than others. There are probably other unidentified strainful background items.

SUMMARY

1. We have presented a study of cultural and social factors in the personal history of 56 women seen in private psychiatric office practice for emotional problems associated with pregnancy and childbearing. We compared these to data obtained from two other groups, one of 116 private patients who delivered normal babies at the Englewood Hospital; the other of 87 young married women referred for private psychiatric office care at other periods than childbearing.

2. The two groups of emotionally ill women differed markedly from the normal controls, but were quite comparable to each other in: (a) Coming from broken homes, and/or having a history of emotional disorder in their parents and/or immediate family. (b) Giving a history of severe physical illness in the past. (c) Having complications in their marriage such as religious and/or significant age differences with their husbands. (d) Rising or falling on the economic or social ladder of success.

3. The obstetrical group of emotionally ill women differed from the group of non-maternity, emotionally disturbed women in: (a) Previous history of emotional disorder. (b) Physical complications of pregnancy. (c) Moving recently to the suburbs. (d) Having older parents. (e) Having an unplanned pregnancy and/or a female child. (f) Undergoing acute strains at the period of childbearing—changing residence, the husband being away from home, receiving no outside help from family or a practical nurse.

4. These data suggest that emotional disorders arising at the time of childbearing may be grouped together as a "maternity psychiatric syndrome" with definite, identifiable, objective, recurring experiences in the patient's family, personal, medical and marital history, plus certain additional acute strains in the pregnancy and childbearing period.

5. It may ultimately be possible to predict which women will develop the "emotional disorders of maternity," and possibly, the severity of the disorder. If this is successful, preventive steps may be taken by providing practical and professional assistance to susceptible women.

6. Our data support the recommendations of most obstetricians and general practitioners that: (a) Pregnant women should be cautious about changing residence until the baby is six months old. (b) Husbands should try to be home during the weeks after delivery. (c) The new mother should have the assistance of an experienced female relative or nurse during the first few weeks at home whenever possible.

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Research Trends in Human Psychopharmacology*

The spotlight in psychiatry seems to be shifting from psychodynamics to pharmacology. However the human mind is not totally analogous to the mind of the animal. Animal experimentation is not as fruitful in psychiatric research as it has been in general medicine and surgery. Nonetheless with proper safeguards, as Dr. Ewing points out, there is a bright future for human psychopharmacology.

Psychiatry utilizes for the most part, a psychologic frame-of-reference for description and investigation of phenomena which have their biologic correlates. To provide the basic scientist with clues as to profitable areas for investigation and to exploit his own data to the fullest, the research psychiatrist must operate within multiple frames-of-reference. The basic disciplines upon which psychiatry rests range from the naturalistic sciences through psychology to the social sciences. Psychology, sociology, social psychology, cultural anthropology, psychoanalysis and even linguistics are making exciting contributions to research in psychiatry.

Each day brings forth a flood of new compounds with anticipated mental effects. Some of these compounds are isolated from natural metabolic processes; some have chemical structural similarity to those occurring in metabolism, and some are products purely of the chemists' ingenuity which have no predictable relationship to normal body function. The bio-chemist and the pharmacologist are bringing their refined technics to bear on the elucidation of the actions of these agents not only *in vitro* and *in vivo* animal studies but in human studies as well. In psychopharmacology human investigation is essential for one cannot predict from animal work the complex emotional and neurophysiologic responses of man. In fact, frequently one cannot predict the responses of normal individuals from those of psychotic persons and *vice versa*.

Psychiatric research poses many difficult problems. There are a bewildering number of variables, many of which are unknown, must be inferred, are uncontrollable or whose essential nature is not determined. The clinician's systems of classification of psychiatric

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disorders are not adequate to allow the prediction of response to specific agents, nor to differentiate quantitatively the effect of similarly acting or chemically related compounds.

There is great discrepancy among reported results of clinical therapeutic drug studies. A recent survey [13] by the Veterans Administration reviewed the reports of 52 investigators. It indicated that improvement with chlorpromazine ranged from 34 to 100 per cent in different series and with reserpine from 17 to 100 per cent. This kind of experience indicates the necessity for moving from reliance upon such criteria of alteration in mental functions as "improved" and "unimproved" to the determination of more specific and better quantifiable factors.

Our research group at the University of Pennsylvania Department of Psychiatry is engaged in a program of investigation within the general area of psychopharmacology. Our studies range from the clinical testing of new compounds through the development of methods for the evaluation of drug effects in humans, to the use of drugs as experimental tools for the elucidation of mental functions. Our efforts to date have impressed us with what we consider to be a lag (although not an absence) in the application of knowledge and technics from psychology and the social sciences to investigation in human psychopharmacology. For this reason and because physicians in other branches of medicine as well as those in the basic medical disciplines are not so familiar with the potential contributions of these specialties we should like to focus discussion on the use of socio-psychologic technics in evaluating drug effects.

Numerous controls can be introduced into the interviewing procedure to make the data more reliable and quantifiable. The use of multiple independent observers who are carefully trained for their specific experimental functions represents one such improvement. High fidelity recording and photography allow for the permanent storing of data for later careful analysis. Numerous studies employ the correlation of ratings from self-assessment with the observational ratings of the investigator. Others include observational data from relatives and other sources. In such studies it is possible to check one type of data against another.

As an example of behavior observation by trained observers, we cite an investigation [1] recently completed by two members of our group on the phenomenologic effects of repeated inhalations of carbon dioxide and nitrous oxide in psychiatric patients. The following types of data were independently collected and correlated: pre-experiment clinical psychiatric interviews, a battery of projective psychologic tests, observed patterns of behavior under each gas, the sensory constants occurring during the induction phase of inhalation of each agent, the dreams occurring under each gas, the night dreams between each exposure session and the free associative material to both types of dreams.

Investigators have used rating scales, check lists, and card sorts with and without forced choice. Where categories of symptoms, behavior and mental functions are refined, these methods make possible the application of newer statistical technics that uncover formerly unsuspected relationships among data which can be found to fall out into discrete clusters and profiles.

Methods involving the quantification of verbal and non-verbal behavior interactions between individuals and within groups have been applied to drug studies. For example, Grinker *et al.*[5] have explored the effects of epinephrine and placebo administered to subjects in a group upon the number of words spoken by each member and upon the various individuals' behavior within an interpersonal setting. This study on experimentally-induced anxiety included prediction of behavior under observation from reaction to past life stresses.

Because of the difficulties in quantifying the clinical psychiatric effects of new tranquilizing compounds, we are setting up an experiment to acquire quantitative data on both ver-

bal and non-verbal behavior of psychotic inpatients in a group setting. In two one-hour sessions per week, independent observers will rate such dimensions as amount of verbal and non-verbal activity, group versus non-group oriented behavior and others which we have reason to suspect may be influenced by drugs. Different types of control will be instituted. In addition to multiple independent raters, the study will use double-blind technic, the experimenters having no knowledge of such matters as drug dose, the identity of a specific drug which each subject is receiving (*e.g.* standard *versus* experimental tranquilizer *versus* placebo) or of drug changes within the group.

In any experiments on humans, emotional factors influence the results. In psychiatric investigation such things as the attitude and behavior of the experimenter toward the subject, the prejudices which the subject brings to the experiment and with which he views the investigator as a person, the setting, and the procedures involved may have important influences upon the results.

By way of illustration, several years ago in studies measuring cerebral blood flow, Kety and his group[7] found that intense anxiety aroused in subjects during the experiment by comments of the investigators induced a very marked increase in cerebral blood flow. Mandler and Kaplan[10] have shown that the subjective evaluation of a neutral verbal utterance (the expression "Mm - hmm") given by an experimenter after every plural noun spoken by subjects influenced verbal performance when the subjects were simply asked to produce all the words they could think of without forming sentences or repeating. All subjects who attached a positive connotation to this stimulus increased their production of plural nouns. Subjects who attached a negative connotation to the same stimulus decreased their production of plural nouns. This occurred without awareness on the part of the individual that the number of plural nouns he produced was changing. The difference in number of plural nouns produced by the two groups was statistically significant.

In preparing to apply a similar technic with certain modifications in studies aimed at increasing our knowledge of how drugs may affect psychotherapy with psychotic patients and the doctor-patient interaction, we repeated Mandler and Kaplan's experiment[10] with normals and obtained results essentially similar to theirs.

The Greenblatt group[3] has been investigating the effects of various types of clinical interview interactions upon certain multiple physiologic variables simultaneously recorded from both subject and experimenter. Eventual application of such methods to the study of drug actions seems feasible.

Interest is developing in the application of tests of learning to problems of psychopharmacology. Problem-solving tests designed to measure insight and tests of trial and error learning (for example maze tests) may be useful for differentiating drug actions. Anxiety impairs the type of learning required in problem-solving tests, but it accelerates the acquisition of certain conditioned responses and prolongs the number of unreinforced trials necessary for extinction of the conditioned responses.[12] It would be interesting to study the influence of different drugs which modify the anxiety reaction upon these particular functions.

Projective technics such as the Rorschach and the Thematic Apperception tests are used to evaluate complex psychologic functions. These require skilled interpretation and they are subject to the bias of the interpreter, although certain separate items can be scored objectively.

The psychology and neurophysiology of perception provide a promising and almost unexplored area for studying drug responses. The literature on perception is extensive and there have been contributions made by workers within such discrepant frames-of-reference as the psychoanalytic and Gestalt.

To indicate briefly an area which we feel

is fruitful for psychopharmacologic research on perception we should like to suggest the following sequential chain as operative in certain cases of mental illness. Human beings react to particular types of life stress with the psychologic phenomenon of anxiety, which has certain physiologic and metabolic concomitants. These aggravate and prolong the anxiety. Anxiety produces failures in perceiving environmental cues essential for adjustmental action. If the stress and anxiety continue for a sufficient period of time, perception becomes increasingly determined by internal conflicts and regressive stereotyped habit patterns. Ultimately, gross falsifications of perception occur. In their structured form these falsifications are the illusions and hallucinations of the acute psychotic patient. If psycho-pharmacologic agents can ameliorate the distinctive type of agitation occurring in the acute psychotic and the anxiety of the psychoneurotic, *demonstrable changes should be apparent in perceptual functions.*

Illustrative of one type of such study is our attempt to examine drug effects using a battery of readily quantifiable measurements such as figure-background discriminations, the formation of a Gestalt from component cues, the rod-frame test which determines the ability of the subject to orient himself correctly to his visually perceived environment, and the ability to discriminate various degrees of closure of a circle when circles with different degrees of arc incompleted are flashed on a screen for only brief durations of exposure.

Within the area of research in perception, we are studying the effect of neutral and emotional words and pictures upon perception as indicated by both verbal report and galvanic skin response, a sensitive measure of autonomic nervous system function. In one phase of this work the word and picture stimuli are successively exposed for different brief intervals with a tachistoscope. The verbal threshold is measured in terms of duration of exposure required for correct identification of the stimulus. The magnitude of the G.S.R. is measured before, during, and after the verbal report. With several modifications, this method will be applied later to certain studies among which will be the testing of drug-induced alterations in these thresholds of visual perception.

Mention should be made of the well-known tests of motor performance and coordination, such as tapping speed and hand steadiness tests, the pursuit meter and reaction times. They are of practical value in terms of determining an individual's ability to perform certain tasks, as in the case of flying an airplane. They are simple to score and administer. However, these tests give very gross data which is difficult to interpret in the light of knowledge about brain and psychologic function.

The psychiatric investigator at this stage in the development of his discipline is vitally concerned with studies correlating clinical psychiatric phenomena not only with psychologic functions but also with physiologic and biochemical measurements. For example, free anxiety has been correlated with blood glutathione levels,[1] corticosteroids in urine and plasma and hippuric acid excretion.

The hippuric acid excretion test originally applied in psychosomatic studies by Grinker, Mirsky, *et al.*[11] as a biochemical measurement of free anxiety has been under recent investigation in our laboratory.[6] By introducing correction factors for weight, age, and urine volume we found it possible to improve the reliability of this test as a quantitative index of free anxiety in non-psychotic subjects, some psychoneurotic and some normal.

To obtain our clinical psychiatric measurement of "manifest free anxiety" we developed a structured psychiatric interview, including a rating scale covering several dimensions of "free anxiety," such as psychologic and physiologic symptoms, observable behavior and observed physical signs. On the basis of this interview the examiners assigned an overall anxiety rating from zero to 6 to each subject. Two trained psychiatrists simultaneously performed the rating on each subject, the one ex-

amining the patient being randomly chosen by the toss of a coin and the other observing from behind a one-way window. In several experiments a third psychiatrist was included.

This study gives some indication of the type of correlations that can be obtained between psychiatric and biochemical data. For example the correlation between clinical psychiatric rating and the hippuric acid index (consisting of a corrected hippuric acid excretion value) was very high and the correlation between the Taylor Anxiety Scale, a psychologic check list, and the psychiatric rating is also highly significant. Actual figures may be obtained from the senior author.

SUMMARY

IN PSYCHIATRIC research there are difficult and only partly solved or still unsolved problems of methodology which deter the quantification of data. The isolation of significant variables and their interactions as well as the formation of better theories and working hypotheses require that the psychiatric investigator think within multiple frames-of-reference, and that he utilize the methods, technics, and theories of the sciences basic to his discipline. These include not only the naturalistic sciences but psychology and the social sciences. Nowhere in psychiatry does this apply more importantly than in the field of psychopharmacology.

The complex psychologic responses of man (whether normal or deviant) cannot be reliably predicted from animal investigations. The traditional clinical criteria are insufficient for accurate evaluation of drug actions in psychiatry. We have here presented a representative review of some areas in which quantitative technics from psychology and the social sciences have been applied to investigation in human psychopharmacology, and have indicated other areas in which such research might be profitably undertaken.

We have sought to illustrate by one of many available examples, the fact that in taking such a working concept as anxiety, it is possible to obtain data in clinical psychiatric investigation which can be well correlated with the results of a biochemical test. Such tests should find ready application in human psychopharmacologic investigation.

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Occupational Medicine 1957*

The physician in industry can be the private practitioner's collaborator. He is never his competitor. The medical director of Esso here frankly discusses this potentially vexing problem.

There seems to be a constantly recurring suspicion that there are some basic conflicts of interest between the private practitioner and the full-time salaried physician in industry. There is no basis for such a conflict if each group understands its responsibilities to the worker-patient.

The physician in industry is concerned with the health of all employed persons rather than that of any limited group of workers in plants or factories. This is implied in the definition of occupational medicine: "that branch of medicine which deals with the relationship of man to his occupation, for the purposes of the prevention of disease and injury and the promotion of optimal health, productivity and social adjustment."[1] Historically, "industrial medicine" has come to encompass primarily the treatment of injury or disease resulting from situations peculiar to the working environment and for which the employer assumes a moral and legal responsibility. Nearly all physicians are called upon to treat such cases from time to time and might well be considered industrial physicians. Disease or injury occurring as the result of defects in the industrial environment is in no wise different from that which occurs among many persons who have never been employed in industry. A strategically placed roller skate on the stairs at home may lead to the same injuries as sustained when falling off a ladder at work. Liver damage and depression of the bone marrow may occur secondary to the improper use of solvents at home or on the job. The indicated treatment in these cases is no different just because of the fact of employment.

The "Return to Work" Examination

Those engaged in the practice of occupational medicine should be concerned with the prevention rather than the treatment of injury or disease. The objective, as in the armed services, is to have as many productive workers as possible on the job at all times. This goal is to be achieved by preventing the occurrence of disability wherever possible. The sick or injured worker represents a failure to achieve the ideal. By and large, the *treatment and rehabilitation of this worker is the job of the private practitioner.* Assessment of this employee-patient's ability to return to the job upon recovery, however, falls within the province of the physician in industry. He alone is in a position to advise management regarding potential hazards to this same employee (or to this employee's associates) which might re-

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1. Conference of the National Fund for Medical Education: the Education of Physician for Industry, Journal of Medical Education, 31:2, March 1956, page 59.

sult from his reduced capacities for his previous assignment. Such responsibility is necessary if the physician in the plant is to carry on an effective preventive program. The working environment includes people as well as machines, fumes, solvents, and so forth.

It is for this reason that employees recovering from prolonged illness or injury are usually examined by the plant physician before they are permitted to return to their jobs. This "return to work" examination is, in many respects, similar to the "preplacement" examination. The doctor's objective in either instance is not to determine whether the patient measures up to certain arbitrary physical standards. Rather it is to decide whether or not his job assignment, or potential assignment, is compatible with his own and his fellow-workers' continued health and safety.

Physicians in industry cannot assure or deny return to the job or initial employment. They merely advise from a medical point of view whether it is in the employee's or potential employee's best interest to undertake a given job assignment. Occasionally there are differences of opinion as to when an employee should return to the job. Also, there may be differences of opinion as to what work the employee may do upon his return. These matters require close collaboration between the private practitioner and the physician in the plant. Unrealistic restriction may result in loss of employment. Premature medical disability retirement may seem attractive to some but is fraught with many social, psychologic, and economic problems. It is not to be considered lightly if the worker's best interests are to be taken seriously.

THE PREVENTIVE PROGRAM

Efforts directed toward the prevention of sickness and injury require many kinds of activity. You, as physicians, are well aware of the dangers associated with permitting a worker with a "strep" throat to dispense the milk, or the girl with a cut finger to stir the mayonnaise, in the plant cafeteria. These, and many other, more or less routine public health problems must be of concern to the plant physician. He must also be prepared to cope with many more subtle health hazards peculiar to jobs or the industry.

The environmental health protection program begins in the research laboratory. Observations by health experts of pilot plant operations can provide data which may be an invaluable guide to those responsible for plant design. Less toxic materials can often be substituted for more toxic substances. All potentially hazardous materials can usually be maintained in closed systems. If leakage is possible, automatic alarm systems, incorporated in the plant design, are desirable. A modern refining unit in operation ordinarily provides fewer hazards than the average home.

Worker contact with potentially hazardous materials is more likely to occur during repair or maintenance procedures. Large operating units may work continuously for periods of 1 to 2 years. At the end of such a period, they must be emptied, cleaned, joints tightened, *et cetera*. Tanks and pipes should be steamed or flushed so as to remove any potentially harmful substances before workers come in intimate contact with them. Appropriate safety and hygiene measures include the use of appropriate protective clothing and respiratory masks, as well as space ventilation and other measures.

Industrial hygiene personnel under the general supervision of the Medical Department cooperate with plant safety personnel in the supervision of such operations. They also carry on extensive testing procedures in an effort to identify potentially hazardous situations which might otherwise escape attention. These tests may be for concentrations of gases or fumes in working areas, the intensity or variety of light, heat, sound, radio-activity, and so forth. Repeat visits and a continuous log of observations in each working area provide assurance to the management, the doctor, and the employee that safe working conditions are being maintained.

The plant dispensary and the examining room provide the final proof that the environmental health program is functioning properly. The acute accident case or the chronic com-

plainer may suggest a defect in the working environment. The doctor, the nurse, and the industrial hygienist are constantly aware of this possibility. A more nearly systematic check of the entire plant's operations, however, is provided by the periodic health examination program. Workers with potential exposure to toxic materials or hazardous situations must be examined frequently or may require certain specific kinds of clinical or laboratory tests at relatively short intervals. Where the employee is known to be in good health and working in a completely innocuous situation, examinations may be performed less frequently.

During the course of periodic examinations, one finds primarily medical problems which are not job-related. These are of interest and concern to physicians in industry. The earliest possible approach to disease, whether curable or incurable, will minimize the disability and extend the period of productive and happy living for the worker. To achieve this goal, *the cooperation of the family physician is needed.* It requires activities outside the sphere of occupational medicine. These activities are in the realm of private therapeutic and corrective medical practice. Most of you have had such problems brought to your attention by employees following their periodic examinations. Feel free to call the examining physician for a discussion of the findings if this will be helpful to you and to the patient.

Certain kinds of cases sometimes create problems for all of us. It is important that medical men, both within industry and private practice, see eye to eye on such problems in the interest of the patient's mental and physical health and well-being. The future of the American economy, and that includes the private practice of medicine, depends to some extent on a satisfactory solution of any existing difficulties.

THE "INDUSTRIAL" LABEL

THE proper labeling of illness or injury as "industrial" is vitally important. In some instances, a casual comment or inference by the family physician is interpreted by the patient to mean that the illness is industrial in origin, and hence compensable, giving rise to an entirely different and more complex medical situation. Of course, occupational illness or injury should be accepted as such by all concerned when the illness is truly "industrial." Perplexing problems arise, however, in situations where the label has been improperly applied. Non-industrial injury and illness are reported to be on the increase among many employee groups. The current "do-it-yourself" era has introduced hazards of all sorts into the home environment that are not permitted in a properly organized industrial plant. Not infrequently, the cause of an alleged occupational illness may be traced to the home workshop of an employee. This is embarrassing to all when it is known that the possibility of the reported injury does not exist in the plant. Decision as to the industrial origin of an illness or injury might well be deferred until you as the family physician have discussed the case with the plant doctor. An honest discussion at the outset will save you, the patient, and ourselves needless expense, effort and anxiety.

ABSENTEEISM

EMPLOYEE attitudes toward sickness absenteeism vary tremendously. Most employees lose no time due to sickness in the course of a year. A very small group of workers, however, looks upon the sickness absenteeism privilege as a justifiable mechanism for obtaining additional time off the job. Most such persons are unhappy, non-productive workers whose aches and pains are psychogenic or sociogenic in origin. They plague physicians both in and out of industry for his signature on a prescribed form. They feel they have discharged their responsibility to their employer and to themselves when they have complied with the letter of the rules and regulations.

Among this group of workers, one finds a number of "alcoholics" or "problem drinkers." Alcohol consumption may be great or little—the amount is of no concern in applying the label "alcoholic." Some industries have spe-

cial programs for the rehabilitation of such employees. In many respects, however, the underlying problem is similar to that presented by other chronically absent or ineffective employees.

The medical profession's responsibility in all such cases is to make the patient face up to his problem honestly at the earliest possible time so that constructive action is possible. A thorough medical evaluation of the worker's physical health must often be supplemented by an investigation of the psychic—and social—spheres. Evasion of this forthright approach to the problem is not a kindness to the employee. He is unhappy, insecure, and ineffective both at home and on the job until his underlying problems are solved. Unfortunately, palliative measures and repeated loss of time from the job over long periods of time are usually inadequate, in many instances, to prevent loss of the job. A tragedy for the individual and his family, to be sure, but also a costly burden to the industry of this country, and, hence, a threat to your and my economic security. Workers who repeatedly lose time from the job because of sickness are either in need of corrective medical treatment or reassignment to a job more nearly compatible with their health capacities.

DISABILITY BENEFITS

Disability benefits, whether temporary, as for sickness, or permanent, as for disability retirement, may be invaluable aids in making economically possible the acceptance of proper medical guidance and treatment. Improperly used, they undermine the employee's self-respect and emotional security. To many, the prospect of economic security, or something approaching that, provides all that they expect of life. If they attain this goal, however, they are usually sorely disillusioned. Employees receive many satisfactions from and have many basic needs fulfilled even by jobs they dislike. Unfortunately, few workers realize this fact prior to the actual separation from the job. Advice to workers concerning premature retirement should be given with great care.

Predictions as to probable resultant disabilities might well be delayed or omitted entirely in the early days of any illness. Only after the disease or injury has been properly treated and adequate rehabilitation measures instituted can one begin to define clearly the residual capacities. Even then, in the interest of the patient's ego, emphasis should always be on abilities rather than disabilities. This is a situation where the worker's best interests, so far as continued health and productivity are concerned, demand the close cooperation of the family and plant physicians.

SUMMARY

The goal of the medical man in industry is to supplement the efforts of the private practitioner and to cooperate with you in providing medical services to patients who work for large industrial concerns. The physician in industry should not compete with you in any way, whether you be a general practitioner, a surgeon, a radiologist, a pathologist, or any other kind of specialist. It is not his purpose to provide free or low-cost services to those who wish to evade their economic responsibility. A proper medical program in industry is a positive one based upon a firm conviction that industry must share, but not take over, the individual worker's responsibility for his own health. This can be done by: first, providing him with a healthful working environment, second, evaluating his health status in relation to his job from time to time, and, third, encouraging his use of your services at the earliest possible time whenever treatment or corrective medical measures are indicated.

15 West 51 Street

County Society Reports . . .

Bergen

The regular meeting of the *Bergen County Medical Society* was held Tuesday, September 10, 1957, at Bergen Pines. It was called to order by Leo J. Fitzpatrick, M.D., president.

New members elected at the June Meeting were welcomed at that meeting.

Dr. George Heller, chairman of the Public Relations Committee, reported that the Bergen Evening *Record* is again cooperating with the Society in presenting two public forums during October.

Dr. Winton H. Johnson, chairman of the Building Committee, made a report on progress in purchasing property on River Road, Teaneck. Purchase price has been fixed at $55,000. The necessary down payments are already in the Building Fund and the balance of $39,100 will be obtained through a 5 year, 5 per cent mortgage. A saving of more than $5,000 could be effected by taking advantage of the clause which permits advance payments without penalty. To make this possible, Dr Johnson proposed an assessment of $75 on each member payable with the dues in January, 1958. Dr. Johnson's proposal will be voted on at a subsequent meeting.

Our guest speaker, Dr. Dickinson W. Richards of Englewood, is Professor of Medicine at Columbia University. Dr. Richards was a co-winner of the Nobel Prize in medicine in 1956.

Dr. Richards gave an interesting talk about the Nobel Festival of 1956 in Sweden. He showed slides of the formal festivities incident to the awarding of the prizes.

At the conclusion of his talk, Dr Richards was presented with an Honorary Membership Certificate by Dr. Fitzpatrick.

The regular meeting of *the Bergen County Medical Society*, held Tuesday, October 8, 1957, at Bergen Pines, was called to order by Leo J. Fitzpatrick, M.D., president.

The Secretary read the following names, which had been approved by the Executive Committee for election: To Associate, Drs. Patrick F. Enright, Frank J. Ferraro, James Fox, Otho F. Knowles, Thomas C. McCormack, John W. McTigue, Joachim Oppenheimer, John P. Sullivan, William C. Van Ost, Arthur W. Wyker; To Regular from Associate, Drs. Yu-Shang Chang, Solomon Chazan, Carl Dvorschak, Richard Lange, Peter F. Madonia, Edward A. Meyers; To Regular by Transfer, Drs. Edward J. Davis and Donald J. MacPherson; To Regular from Active Service, Dr. Donald V. Leddy: To Courtesy, Dr. Aaron Weiner: Reinstatement to Regular (from military service) Dr. Ranald MacDonald.

The President announced that the Scholarship Fund had now grown to such a size that grants should shortly become available for qualified medical school students and that he had been requested to appoint a committee to screen applicants for these grants. The committee appointed is Dr. L. A. Mulligan, chairman, Drs. G. O. Rowohlt, G. B. Barlow, W. T. Knight and Preston Price.

The following resolution was passed:

Whereas, the Medical-Surgical Plan gives recognition to the surgeon in providing a fee schedule for operations and,

Whereas, provision is made for only 21 days of medical treatment in hospital for medical illness and,

Whereas, many serious medical diseases require a longer in-patient stay; for example, myocardial infarction with a minimum of 28 hospital days and,

Whereas, this and other serious medical illnesses require expert care and more visits and time than allowed for by present $5 per day fee and,

Whereas, it is obvious that the internist and general practitioner treating serious illness are unfairly treated by the present Medical-Surgical Plan.

Therefore be it resolved, that steps should be taken to erase this injustice and bring medical fees to a par with surgical fees as soon as reasonable in the present contract of the Medical-Surgical Plan known as "The Doctor's Plan" and that the contract be rewritten or amended.

Dr. Palazzo, chairman of the Insurance Committee, announced that only 162 applications for Blue Shield group insurance have been received. He stated that 300 were needed to qualify for a group contract and that unless the necessary additional applications were received, the effort to establish a group contract would be abandoned.

Resolutions memorializing the deaths of two members, Dr. August W. Moser and Dr. Anthony M. Romano, were passed unanimously.

The Society voted to adopt the budget proposed by the Committee.

Dr. W. H. Johnson, chairman of the Building Committee described in detail a lot at 1286 River Road, Teaneck, and the historic building on it. An independent appraisal of the property gave us a reasonable market value of $60,840. Dr. Johnson then presented the following resolution and moved its adoption:

Resolved, that the Bergen County Medical Society purchase the Davis property located on River Road, Teaneck, N. J., known as lots 2A and 3A in Block 117 for $55,000.

The motion was seconded. There was discussion of zoning variance requirements, establishment of a clear title, limitations on size of meetings possible, removal of deed restrictions, renovation requirements and/or needed repairs. The vote was by written ballot. The tellers announced that 66 had voted in favor of the resolution while 30 had voted against it. The resolution was adopted.

Dr. Johnson read the following resolution and moved its adoption:

Resolved, that the members of the Bergen County Medical Society agree to pay an assessment of the sum of $75 each, payable with the Society 1958 dues due January 1, 1958 (except that those members who have been in practice less than three years as of January 1, 1958, may elect to pay this in $25 annual installments), and

Be it further resolved, that all new Associate Members joining this Society subsequent to January 1, 1958, may have the privilege of paying this assessment in three consecutive equal annual installments, and that all new regular members be assessed the full amount, and

Be it further resolved, that if any member considers that payment of this assessment creates for him a financial hardship, he may appeal to the Executive Committee which is empowered to make any adjustment it deems equitable in any individual instance.

This resolution was carried by a standing vote.

At this point, it was moved, seconded and passed that the chairman of the Building Committee be accorded a rising vote of appreciation for his diligent, protracted efforts on behalf of this Society.

The film provided by the A.M.A., *The Medical Witness,* was shown.

CHARLES P. CAMPBELL, M.D.

Reporter

Cumberland

The regular meeting of the *Cumberland County Medical Society* was held at Rainbow Lake on October 8, 1957 with Dr. Paul K. Ayars of Port Norris Millville, presiding. There were 27 members present.

Dr. Jerome M. Cotler was unanimously elected to active membership as a transfer from the Philadelphia County Medical Society. Dr. Costabile A. Cilento, having been an associate member of the Cumberland County Medical Society for the required period was also elected to active membership.

The amendment to the By-Laws of the Cumberland County Medical Society's Constitution which involved the election of officers was revised to read: "Election of officers shall take place in the April meeting, but officers then elected, shall be installed at the June meeting, which shall be known as the Annual Meeting."

Dr. Harry A. Reinhart of Vineland, Chairman of the Cumberland County Judicial Committee, explained the function of his committee and the *modus operandi* of the committee and council at county and state level.

Dr. M. David Baxter, Program Chairman, introduced the guest speaker, Dr. A. Henry Clagett, Jr., Chief of the Cardiovascular Section, Memorial Hospital, Wilmington. He gave a discourse on "Cardiac Arrhythmias" in which he discussed the classification, the diagnosis, the treatment, and the drug of choice. He pointed out that many of these seemingly abnormal heart beats are benign in character and may be seen in emotional individuals, smokers, drinkers and those in whom there is a focus of infection, such as bad teeth or gall bladder disease. Dr. Clagett's talk was apropos, instructive, and practical.

LEONARD G. SCOTT, M.D.

Reporter

Middlesex

The regular monthly meeting of the *Middlesex County Medical Society* was called to order by Dr. G. R. Gessner, the president at 9:00 p.m., October 23, 1957, at Roosevelt Hospital.

The minutes of the annual dinner meeting were accepted as read by the Secretary, Dr. Zullo.

Dr. Raymond J. Gadek, Chairman of the Pharmaceutical Liaison Committee discussed the joint November meeting with the Pharmacists.

Dr. William Rubin, Chairman of the Public Relations Committee reported that there was a meeting of public representatives of the county concerning Asiatic influenza. Suggestions were made to the public and releases to the newspapers.

The County Medical Society received favorable editorials in the local newspapers concerning the Eye Health Screening Week, which was a success.

Dr. Rubin reported on a letter written to the AMA from a patient in Middlesex County concerning the availability of emergency medical care. To remedy the situation, it was suggested that phone numbers be published in local papers for coverage, or that an emergency panel be furnished. Dr. Sandella also made the recommendation that copies of this letter be given to the doctors in the area involved. The matter was referred to the Public Relations Committee for further action.

The problem of dues was discussed since an extra ten dollars assessment for membership in The Medical Society of New Jersey for 1958 was involved. It was proposed that the County Medical Society pay five dollars from its treasury and that each member pay five dollars toward the increase in 1958 dues. This was unanimously passed. The Society also approved a salary increase for the office secretary.

Dr. Robert Zullo then read a letter from a local factory concerning the need for a panel of doctors to determine disability discontinuation in the event of disagreement between doctors. The Secretary was instructed to answer this letter so that the matter could be handled to the common satisfaction of both labor and management.

A brief review of the proposed Revised Constitution and By-Laws was given by Dr. Calvin, Committee Chairman. Each member present received a mimeographed copy of the proposed revision. The Board of Trustees also received copies of the present Constitution and By-Laws.

RUDOLPH G. MATFLERD, M.D.

Reporter

Monmouth

Monmouth County Medical Society held its regular meeting on October 23 at Fitkin Memorial Hospital, with Dr. Theodore Schlossbach presiding.

Dr. N. Craig Roberts, Long Branch, was elected to active membership on transfer from the Nevada Society. Associate membership was granted to Dr. Edward Bernhard.

A resolution was offered by Dr. Harold Kazmann and passed by the membership, that the County of Monmouth be urged to raise its appropriation for hospital care of the indigent from $350,000 to $600,000 as provided in Assembly Bill A409.

The speakers for the evening were: Dr. Louis F. Albright whose topic was "The Purposes of the Medical Society," Dr. C. Byron Blaisdell who spoke of "The Function of the State and National Societies," and Dr. Daniel F. Featherston who discussed "The State Judicial Council and the County Judicial Committee."

DONALD W. BOWNE, M.D.

Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* included an Installation Dinner, introducing Dr. Samuel C. Yachnin, the new president. The meeting was held at the Alexander Hamilton Hotel on Thursday, September 19, 1957.

Dr. Theodore K. Graham, Chairman of the Dinner Committee, called upon the Rt. Rev. Monsignor John J. Shanley to give the invocation.

After the dinner, a short business session was held at which the following were elected to Active Membership: Dr. Sigurd E. Johnsen of Passaic, Dr. Salvatore Sapienza, Dr. Hyman J. Levine of Paterson. Elected to Associate Membership were: Dr. Herbert L. Cole, Dr. Charles M. Lewis, Dr. Herbert S. Rosenthal, Dr. Victor J. Weil, Dr. Edward A. Wolfson of Paterson. Dr. Oscar J. Krieger, Dr. Roy R. Singer of Fair Lawn, Dr. Charlotte Lomova of Clifton, Dr. Earle N. Rothbell of Passaic, and Dr. Murray Strober of Nutley.

Dr. Sandor A. Levinsohn, who served as toastmaster, was then introduced.

Dr. Abraham Shulman, the retiring president, was presented with a plaque in appreciation of his services during the past year, and he acknowledged this gift with thanks.

Dr. Samuel C. Yachnin, the newly elected president addressed the group. He emphasized the theme "Improving Upon the Relationship Between Doctors."

The other officers installed were: Dr. Theodore K. Graham, First Vice-President; Dr. Julian Cohen, Second Vice-President; Dr. Joseph F. Moriarty, Secretary; Dr. Frank B. Vanderbeek, Treasurer; Dr. David B. Levine, Reporter; Dr. John A. Ianaeone, Editor.

Guests at the dinner included Dr. Albert B. Kump, President, and Mr. Richard I. Nevin, Executive Officer, of The Medical Society of New Jersey; Mayor Edward J. O'Byrne of Paterson—all of whom addressed the group briefly; also Mr. John F. Crane, Superintendent of The Paterson General Hospital; Mr. Harvey Schoenfeld, Director of Barnert Memorial Hospital; Mr. Joseph A. Mattson, Director of the Passaic General Hospital; Mr. David Wachs, Superintendent of the Beth Israel Hospital. The Bergen County Medical Society was represented by Dr. Leo J. Fitzpatrick, President, and Dr. George Heller, First Vice-President. Dr. Louis Lipton, Dr. Jacob Roemer and Dr. Andrew B. Vanderbeek, Emeritus Members and Dr. Hiram Williams, Honorary Member of The Passaic County Medical Society, were also among the guests.

Dr. Levinsohn then introduced the principal speaker of the evening, Leonard A. Scheele, M.D., former Surgeon-General, United States Public Health Service; President, Warner-Chilcott Laboratories. Dr. Scheele's topic was "Health Progress and Problems."

The regular monthly meeting of the *Passaic County Medical Society* was held on Tuesday, October 15, 1957 at the Medical Society Building. Dr. Samuel C. Yachnin, the President, presided.

The following physicians were elected to membership: Active Member—Alfred Widetsky of Paterson; Associate Members—Richard Fadil of Garfield, Anthony R. Gennaro and David M. Niceberg of Passaic, Don T. Van Dam of Oakland.

Dr. Theodore K. Graham, Chairman of the Finance Committee, read the report of his committee for the year. It was moved that the report and recommendations of the Finance Committee be adopted as presented. The complete report will be in the November *Bulletin*.

The Secretary then read resolutions on the death of three members of the Society: Peter D. Westerhoff, Joseph H. Oram and Samuel Ginsburg.

Refreshments were then served and a social hour enjoyed.

DAVID B. LEVINE, M.D.

Reporter

Salem

The *Salem County Medical Society* met on Friday, October 18, 1957, at the du Pont-Penns Grove Country Club. The principal speaker was Dr. Robert McAllister of the South Jersey Medical Research Foundation. He spoke on the recent advance in the treatment of infectious diseases at the Camden Municipal Hospital.

Dr. McAllister also reported on plans for the closing of the Camden Municipal Hospital as a

Contagious Disease Center. The Camden City Commissioners want information from the eight counties which have been sending patients to the Camden Municipal Hospital concerning their willingness to contribute a pro-rated amount to the overhead expenses of the hospital. The city will then exclude patients from counties which are unwilling to contribute.

Dr. W. Garrett Hume, presiding, reported on his presentation to the Salem County Board of Freeholders. At that time the problem was referred to the committee on Charities and Correction, which will send a delegation to Camden to meet with the Camden City officials. New members elected to the Society at this meeting were Dr. Joseph Stasney, pathologist at the Salem County Memorial Hospital, and Dr. Dorson S. Mills of Elmer. Dr. William Sprout gave a report on a recent meeting of the Salem County Council for Public Health Services and the Society approved a resolution to cooperate with this council in its proposed survey of Public Health conditions in Salem County. A committee was appointed to assist the council, composed of Drs. Sprout, Albert Sungenis, Joseph Stasney and C. Spencer Davison.

W. L. SPROUT, M.D.
Reporter

Announcements • • •

Medical Detailmen . . . "Angels"

A group of medical detailmen in the North Jersey area have become "angels" by sponsoring a series of puppet shows for children. The New Jersey Medical Sales Representatives Association, an organization of the leading pharmaceutical firms, organized to promote greater cooperation between the medical and allied professions, gave the first showing of their puppet show to the pediatric patients of St. Mary's Hospital in Hoboken on October 28.

Ted Taylor of West Orange was the puppeteer, assisted in the staging and sound effects by Tom Livera of Newark and Jerry Wolf of Bergenfield. The rest of the crew, Sal Aiello of West New York, Frank Mirabelli and Peter Jugan, both of Washington Township, moved beds, carried ailing youngsters, and generally acted as hosts. After the show, President Alvin Mechanic of Fairlawn presented cheer packets of toys and candy to the children. Everyone had a good time—especially the grownups!

The next venture of the detailmen as impressarios took place at Teaneck's Holy Name Hospital on December 7. They will also sponsor and operate the puppets at the annual Christmas party of the Woman's Auxiliary of the Bergen County Medical Society. These service representatives are from Fougera, Wyeth, Stuart, Eaton, Schenlabs, and Schering Corporation.

Industrial Medicine Show

An Industrial Health Conference will be held April 19 to April 25, 1958, at the Atlantic City auditorium. This convention comprises the annual meetings of five national organizations: The Industrial Medical Association, The American Industrial Hygiene Association, The American Conferences of Governmental Industrial Hygienists, The American Association of Industrial Nurses and The American Association of Industrial Dentists. For program, write to: J. H. Wolfsie, M.D., American Cyanamid Company, Linden, N. J.

Medical Writing Prize

The Delaware Valley Chapter of the American Medical Writers' Association announces the Silberman Foundation Award for Medical Writing. The first prize is $200. Only interns and residents are eligible and the submitted document must be a previously unpublished case report. For more details write to Dr. Hugh Robertson, 255 South 17th Street, Philadelphia. Deadline for submission of material is March 1, 1958.

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Clinical Toxicology of Commercial Products. By Marion N. Gleason, Robert L. Gosselin and Harold C. Hodge. Baltimore 1957. Williams and Wilkins. Pp. 1160. ($16.00)

One of the first pages of this book has a diagrammatic illustration of how to extract from the manual the voluminous information it contains. Directions are given to various sections of the book, depending upon whether you know the ingredients of the poisonous material, or whether you know only the trade name. Cross-reference directions are also provided, enabling the reader to determine toxicity data for given ingredients or probable ingredients.

This volume contains over 15,000 trade names of products which might be ingested accidentally or suicidally. This trade name index is printed on distinctive yellow pages. The ingredients of each product are listed and those which, when ingested, may be responsible for major toxic effects, are marked by an asterisk.

An introductory section deals with first aid and emergency treatment of poisonings, stressing the value of a universal antidote powder, as well as providing a list of equipment useful in the treatment of chemical poisoning. This is a valuable guide for physicians, for the equipment of a rescue squad or emergency facilities in the accident room of hospitals and industries.

A second section has over 1,000 ingredients in an alphabetical compilation of the chemical substances which are commonly found in the commercial products used by the consumer around the home and farm. An estimate of the toxicity rating of each product is indicated.

A third section summarizes clinical and experimental data on 68 classes of compounds, stressing the toxic signs, symptoms and recommended programs of therapy. Allergic reactions receive only casual mention. No attempt is made to record the untoward reactions encountered when drugs are used in customary doses.

Section Four deals with the supportive treatment of chemical poisoning. The data here are valuable for physicians, nurses, safety inspectors, and rescue squad personnel, who may be involved in rescue operations, poisonings or other accidents involving human beings.

Section Six gives several hundred formulas for products and preparations commonly found in households and on farms. These formulas are provided for orientation of the physician who may want to know the kinds of materials usually employed, their toxicity and the quantity and nature of the toxic components of various compounds.

The final section of the book provides an alphabetical index of manufacturers' names and addresses, for the convenience of any one who might need to telephone or write for additional information concerning any of the 15,000 products listed.

The authors are to be congratulated upon having presented an enormous amount of toxicologic data and arranged it in an accessible manner. The manual is recommended as a ready reference for physicians, nurses, pharmacists, rescue squad workers, and others who have to deal with poisoning. Poisoning causes the death of eight persons daily in the United States, because of the multitude of chemical products which are in daily use throughout the American farm and home.

THOMAS K. RATHMELL, M.D.

Chronic Illness in The United States. Volume 1, Prevention of Chronic Illness. By The Commission on Chronic Illness, Cambridge, Mass., Commonwealth Fund and Harvard University Press, 1957, Pp. 338. ($6.00)

This book is the first in a four-volume series designed to present the findings and recommendations of The Commission on Chronic Illness. This national group dates its origins to the pioneer concern with improving the care of the chronically ill initiated by the New Jersey Department of Institutions and Agencies under Dr. Ellen C. Potter over twenty years ago. The present study concerns the necessity of preventing the occurrence and progression of chronic disease and disability.

The first part of this volume discusses such topics as the promotion of health, prevention of illness, early detection of disease through periodic health examinations and multiphasic screening tests, health workers, education and related community planning.

The second part of the book is a series of concise summaries of the status of preventive measures for major chronic diseases and disabilities. These include arthritis and rheumatism, blindness, cancer, cardiovascular diseases, cerebral palsy, diabetes mellitus, epilepsy, impaired hearing, mental illness, multiple sclerosis, poliomyelitis, syphilis, tuberculosis, occupational disabilities, dental problems, malnutrition and obesity, and emotional factors in chronic diseases.

Prepared by authorities in various subjects, these summaries will be useful to physicians, nurses, public health and social workers. This volume is recommended for all who are concerned with today's important problem of chronic illness in the United States.

FRED B. ROGERS, M.D.

Fads and Fallacies in the Name of Science. Martin Gardner. New York, 1957. Dover Publications. Pp. 363. (Paper) ($1.50)

Should doctors expose medical frauds? Or are their motives suspect, their methods inadequate and their time too limited? There are those among us who argue that every American has an inalienable right to be a fool if he wants to and to wreck his body according to his own crotchets. There are others who say that the physician is false to his oath if he does not try to educate the public against quacks, cultists, and crackpots.

One of the difficulties in exposing medical fakery is that the doctor can rarely document his criticism. He does not possess the instruments of propaganda needed, his motives are questioned and he lacks the time. Here is where this book comes in. Mr. Gardner deals with a dozen medical fantasies from iridodiagnosis to zone therapy. He tells the story in sprightly fashion, and gives enough references to enable any one to track down the documentation he needs. He includes not only the obvious fakes and the manifest cults, but also such borderline developments as osteopathy, progressive relaxation, graphology, and psychodrama. Each chapter is supplemented with notes and comment which add to its interest.

In addition to zany medical ideas, the book covers a variety of noodleheaded curiosa from belief that the earth is flat to a faith in dowsing rods. The work is absorbing, and the reader turns each page with high curiosity as to what is next. Mr. Gardner does a public service by offering a counterweight to the tawdry publicity which always seems available to crackpot ideas. The book should be available in the library of every medical society's speaker's bureau and public relations office. Indeed, this glossary of gullibility should hold the interest of every sophisticated reader.

Victor Huberman, M.D.

The Visual Fields: A Textbook and Atlas of Clinical Perimetry. By David O. Harrington, M.D., Pp. 314. St. Louis, C. V. Mosby, 1956. ($16.00)

Dr. Harrington is a well known neuro-ophthalmologist and teacher of perimetry.

Part One in the book takes up the examination of the visual fields. The "black light" perimeter which the author invented is growing in popular use.

Part Two takes up defects in the visual fields. Here will be found a wealth of information about diseases of the retina, optic nerve, chiasma, and post-chiasmal pathology.

This is probably the best book on the subject and should be in the hands of every neuro-surgeon, neurologist and ophthalmologist.

Thomas D. Monte, M.D.

Signs and Symptoms. Edited by Cyril M. MacBryde, M.D., with contributions by 28 other physicians. Pp. 973. Ed. 3. Philadelphia 1957, Lippincott. ($12.00)

Increasing reliance on laboratory findings has blunted the formerly sharp edge of the clinician's acumen. This book, like the two previous editions, is an effort to resharpen the edge. A chapter on growth and sex development, one on lymphatic disorders and a third on vasospasm represent additions to the second edition.

Each chapter covers a major symptomatic area (pain, palpitation, hemoptysis and so on), and differential diagnosis is then discussed. As with all anthologies, there is considerable unevenness of quality. There is also a tendency for each author to stress his hobby—as for instance, a disproportionate amount of headache space is given to migraine, since that has long been Harold Wolff's field of expertise. Similarly, the editor of the book is especially enchanted by problems in nutrition, growth and development, so that he devotes 28 pages to obesity as a diagnostic sign, 40 to poor nutrition and 39 to growth and development. But, on the whole, the book is practical and will launch any physician on a chain of ideas, as he consults MacBryde to get a clue from a presenting symptom.

Ulysses S. Frank, M.D.

Practical Diagnosis and Treatment of Liver Disease. By Carroll M. Leevy, M.D., New York, 1957. Harpers. Pp. 336. ($8.50)

Many treatises on the liver are of vast size and are filed with tangential details. By contrast, New Jersey's own Dr. Leevy has here written a precise and compact monograph on the physiology and pathology of the liver. This book does not overwhelm the reader by its size nor does it disappoint one by its elisions. The text consists of eleven chapters. Each chapter is followed by generous references. A composite approach to the study of the liver is followed by a chapter on clinical diagnosis. The material on liver function studies is excellent. There then follows a chapter on diagnosis. Liver disease is then discussed along anatomic lines. Dr. Leevy was one of the pioneers in needle biopsy and this chapter is well worth reading. The remainder of the book covers general principles of therapy and various types of intrinsic liver disease, along with liver disease due to biliary dyscrasias.

Dr. Leevy is well known here in New Jersey through the years by his exhibits, his papers and his lectures. It is fortunate for us that he has compiled these in such a concise and workable monograph.

Andrew J. V. Klein, M.D.

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† Obituary
e—Editorial
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ab—Abstract

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* Original Article
† Obituary
e—Editorial
br—Book Review
ab—Abstract

TUBERCULOSIS Abstracts

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Vol. XXX December, 1957 No. 12

Basic Problems in the Diagnosis and Management of Tuberculosis

By Howard M. Payne, M.D., The West Virginia Medical Journal, May, 1957.

Early Diagnosis. The photofluorographic process and the wider use of X-rays disclose many thoracic lesions which when not frankly tuberculous, require careful clinical study and observation. On general hospital care this may be an expensive procedure. The concept of an asymptomatic illness which has not caused a loss or impairment of physical power is rarely familiar to the patient and he is apt to regard the physician who insists on clinical studies with faint ridicule. Here obviously we need a program of extended education which will teach the public and many general practitioners the need for early studies of chest X-ray findings in the absence of symptoms.

The Influence of General Factors. It is well known that economic and vocational status influence the potential severity of a tuberculous lesion. Among young women the probability of an apical lesion becoming active increases with pregnancy, particularly if the standard of living is low. Tuberculous lesions are potentially active among the aging, particularly among pensioners who have lowered their standard of living, or have substituted alcohol for more nutritious elements of diet. Among those under 5 years of age, a tuberculous infection is generally to be regarded as carrying a grave prognosis.

Intercurrent Disease. Patients with diabetes in any age group are prone to develop progressive tuberculosis. The combination of an X-ray lesion and diabetes is a signal for vigorous study and early treatment.

Malnutrition. Malnutrition may be a serious contributing factor to tuberculous activity and progression.

Industrial Dust Exposure. The combination of exposure to silica dust and tuberculous infection precedes the development of massive progressive disease in the lung. Similarly the combination of tuberculosis and pneumoconiosis of coal workers apparently leads to a massive progressive fibrosis which can be recognized from characteristic X-ray findings and the history of dust exposure. The patient's general background should be considered, once an abnormal chest X-ray is found.

Factors in Differential Diagnosis. Aside from the background of the patient differential diagnostic studies are needed. These vary according to the type of lesion. A high index of suspicion is a paramount need in the recognition of bronchial and other forms of thoracic carcinoma. One must be prompt to use surgical consultation and bronchoscopy. It may be well to remember that recurrent episodes of pneumonia or shortness of breath, of nonproductive persistent cough, of chest pain or hemoptysis, may be more significant than the X-ray findings. Inexplicable thoracic symptoms always require careful study to rule out carcinoma.

Other Chronic Pulmonary Diseases. Many of the other chronic pulmonary diseases such as bronchiectasis, suppurative pneumonitis and chronic emphysema can be recognized from a careful radiologic study and a clinical and laboratory evaluation. Testing of sputum for tubercle bacilli is always a wise precaution.

Tuberculin Testing. The intradermal tuberculin test is a basic diagnostic weapon. At the present time there is considerable disagreement concerning the meaning of positive reactions obtained with strong dilutions of tuberculin. There is a possibility that positive reactions to strong dilutions are due to some cross sensitivity rather than to tuberculous allergy. Many clinicians regard induration in excess of 5 mm. largest diameter as positive only when the maximal doses employed are 0.0002 mg. of PPD or

0.1 mg. of OT. Completely negative reactions to the intermediate dosage, or larger, rules out the presence of tuberculosis in the absence of a premorbid state, cortisone or ACTH medication or extremely high fever. Many adults in middle-age have negative reactions and our diagnostic problem is thereby simplified.

Sputum Testing. Three successive morning specimens of the sputum when pooled and examined by smear and culture give evidence of the presence of tubercle bacilli in the majority of new cavitary cases. This method is as reliable as the patient who collects the specimen according to instructions.

In too many cases expectoration is absent. Gastric lavage is satisfactory on patients under study in the hospital but it is not practical as an office or clinical procedure. On our service we have studied the inhalation of nebulized water as a means of provoking cough and expectoration. By this method a penicillin nebulizer pump is employed, attached to a De Vilbiss #41 nebulizer. Sterile water is inhaled by the patient until cough and expectoration produce an adequate specimen. This method is used both in the diagnosis and control of treatment. It appears to be applicable to ambulant cases where gastric lavage cannot be done.

Problems in Treatment. The basic treatment of tuberculosis is dependent upon the following factors ;

1. Adequate bacteriostasis through drugs.
2. Healing of the damaged lung through rest, nutritional management and graded exercise.
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The antituberculous drugs diminish the inflammatory changes in the lung by suppressing bacterial growth. Healing of tuberculosis depends upon rest, adequate dietary management and treatment of other illnesses. The medical management of the damaged lung is hardly possible without hospitalization.

The aging patient, the alcoholic, the diabetic, manage the healing of tuberculosis poorly and remain disabled for longer periods than younger patients who heal more rapidly once the suppression of bacterial growth is accomplished.

For all patients whose inflammatory residues remain after 4 to 6 months of drug therapy, surgical excision or, more rarely, surgical collapse is necessary. This is best done after adequate drug therapy and a study of the patient's breathing capacity, both being hospital procedures.

There are many patients with a history of lung exposure to coal dust who exhibit extensive disease on the X-ray, a positive sputum, and some degree of respiratory disability. These men have pneumoconiosis of soft coal workers, with tuberculosis and progressive massive pulmonary fibrosis. Drug therapy may control the growth of bacilli, fever and malaise disappear, and there is an increased sense of well-being. However, dyspnea does not improve nor is there appreciable X-ray clearing. In our opinion these men can be discharged only to the most vigilant medical supervision and even then remain potential spreaders of tubercle bacilli. The early and vigorous treatment of all lung infection of soft coal workers seems indicated.

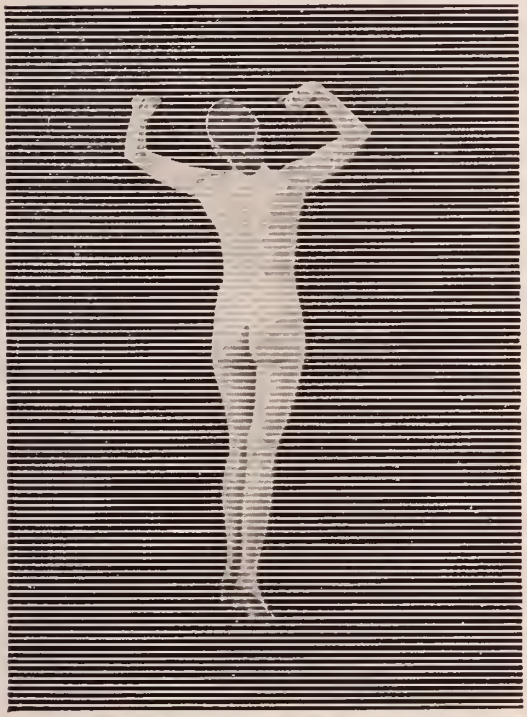
These patients and the aging are those most difficult to treat. Younger patients with no dust exposure recover and are discharged. Many others remain capable of spreading infection despite apparent recovery. For these we need hospital care and isolation, lacking clinical and home care facilities at their homes.

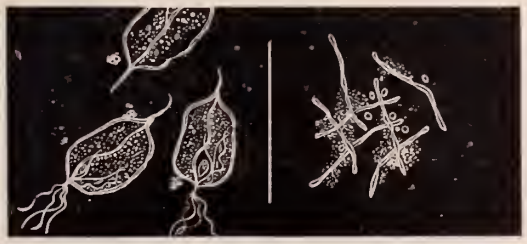
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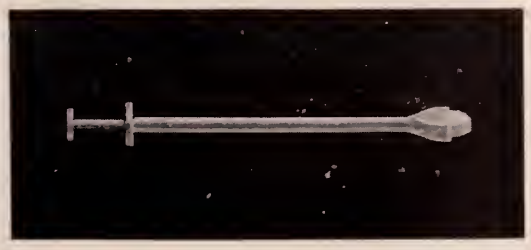
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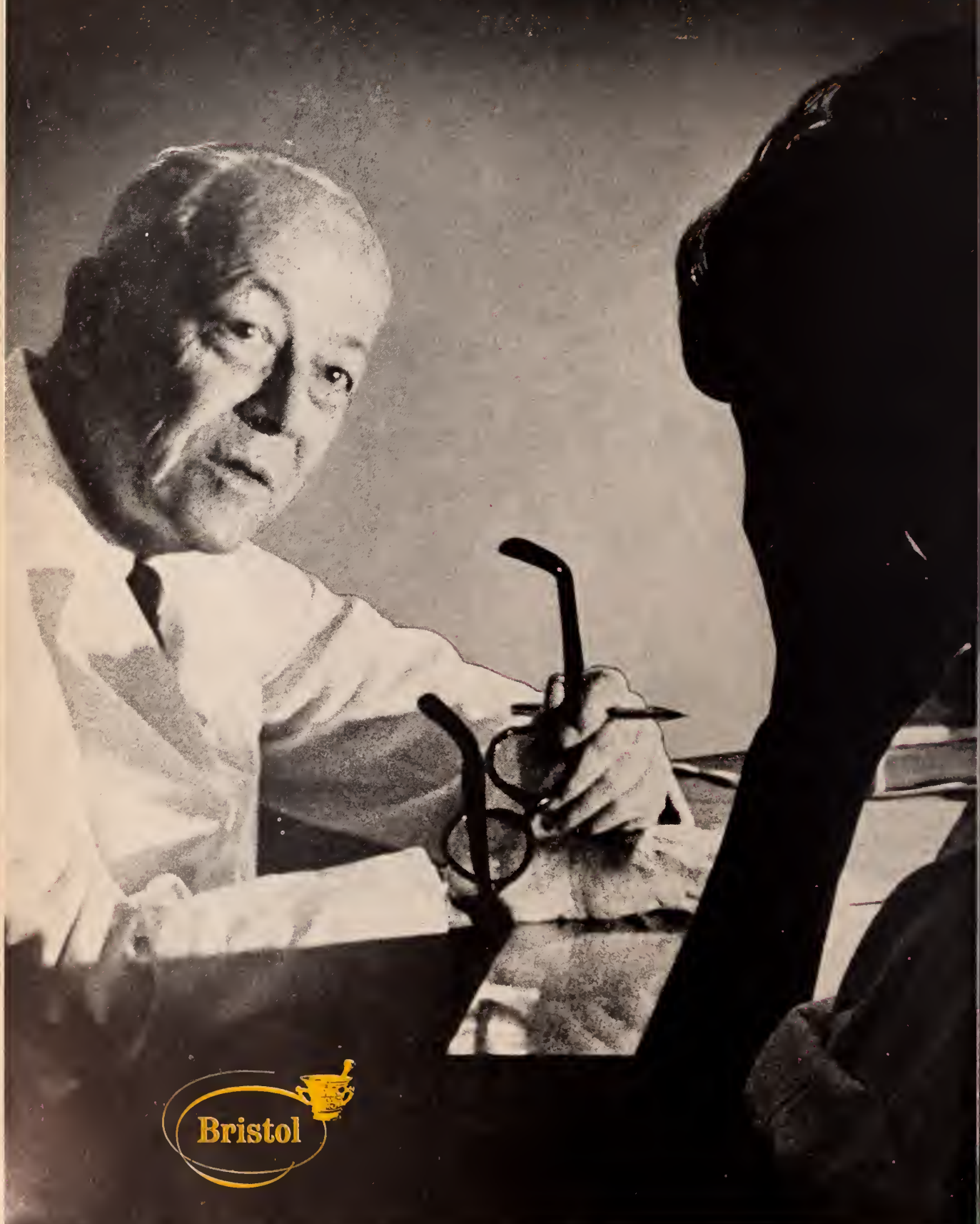
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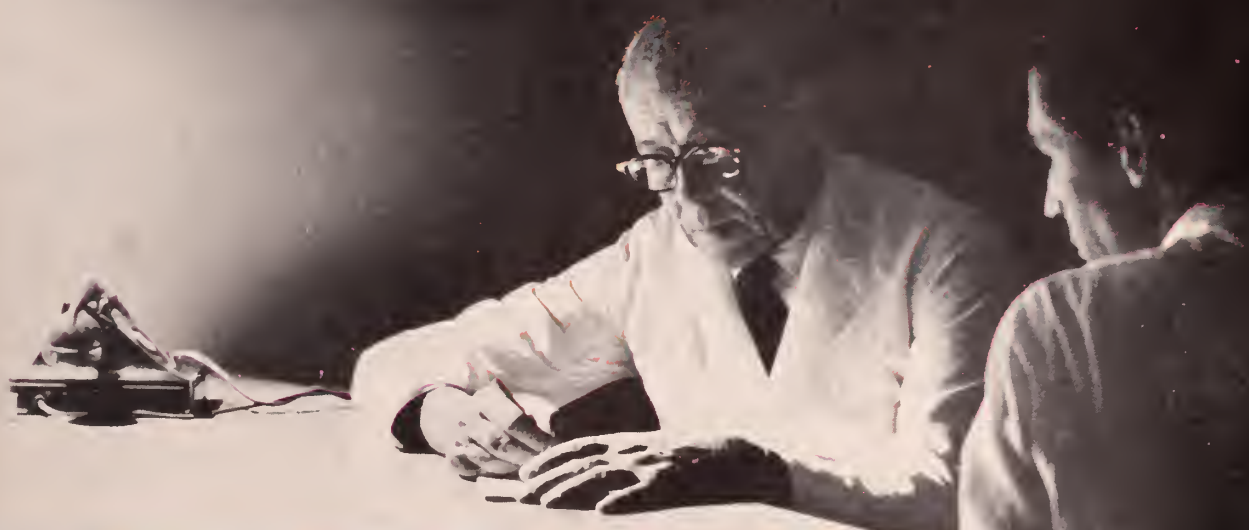
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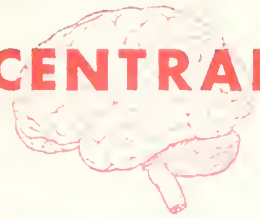
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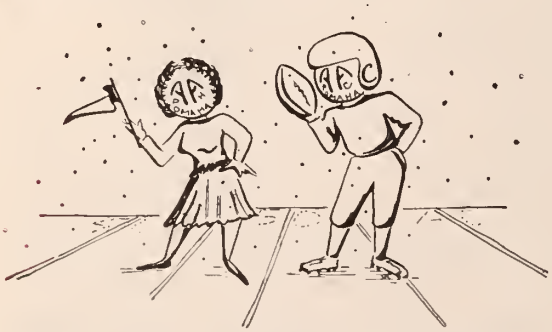
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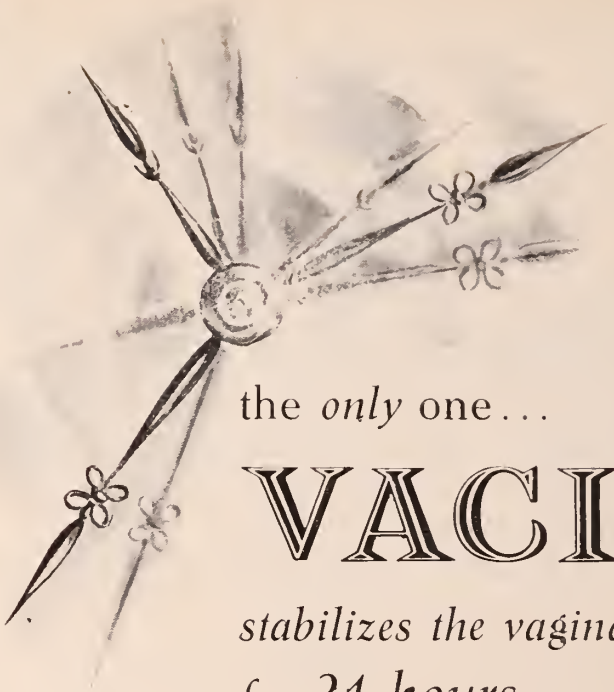
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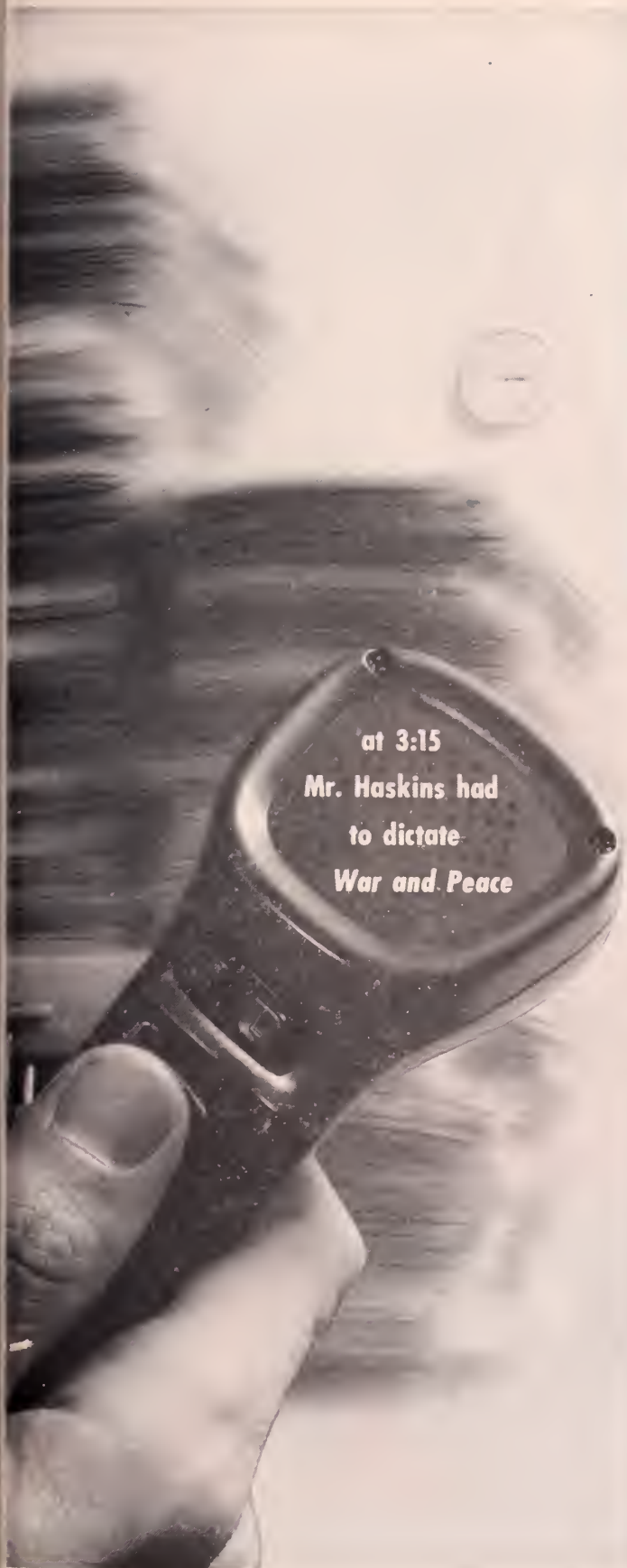
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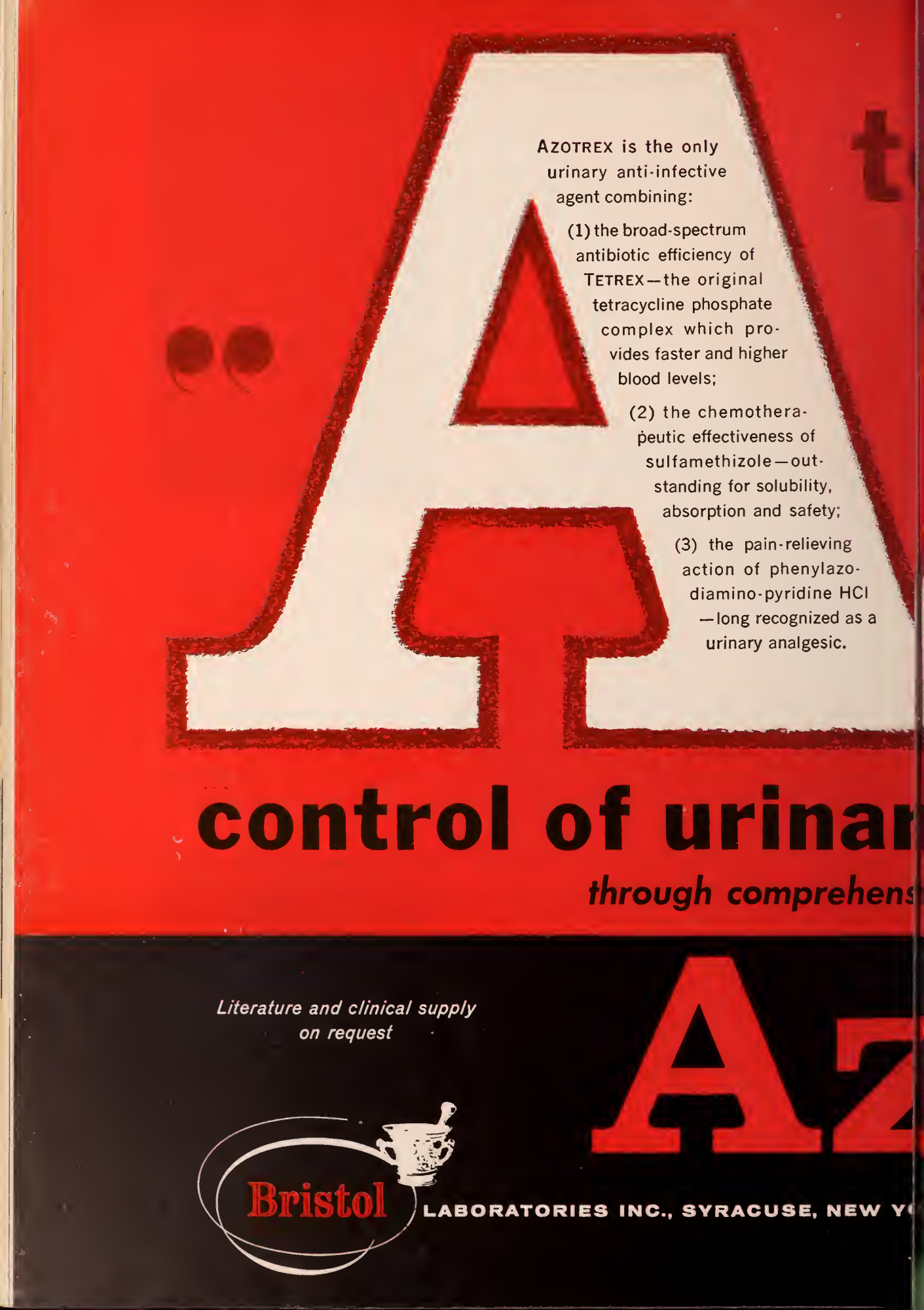
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1. Winsor, Trovis: Comparative Effects of Various Rauwolfia Alkaloids in Hypertension; *submitted for publication.*


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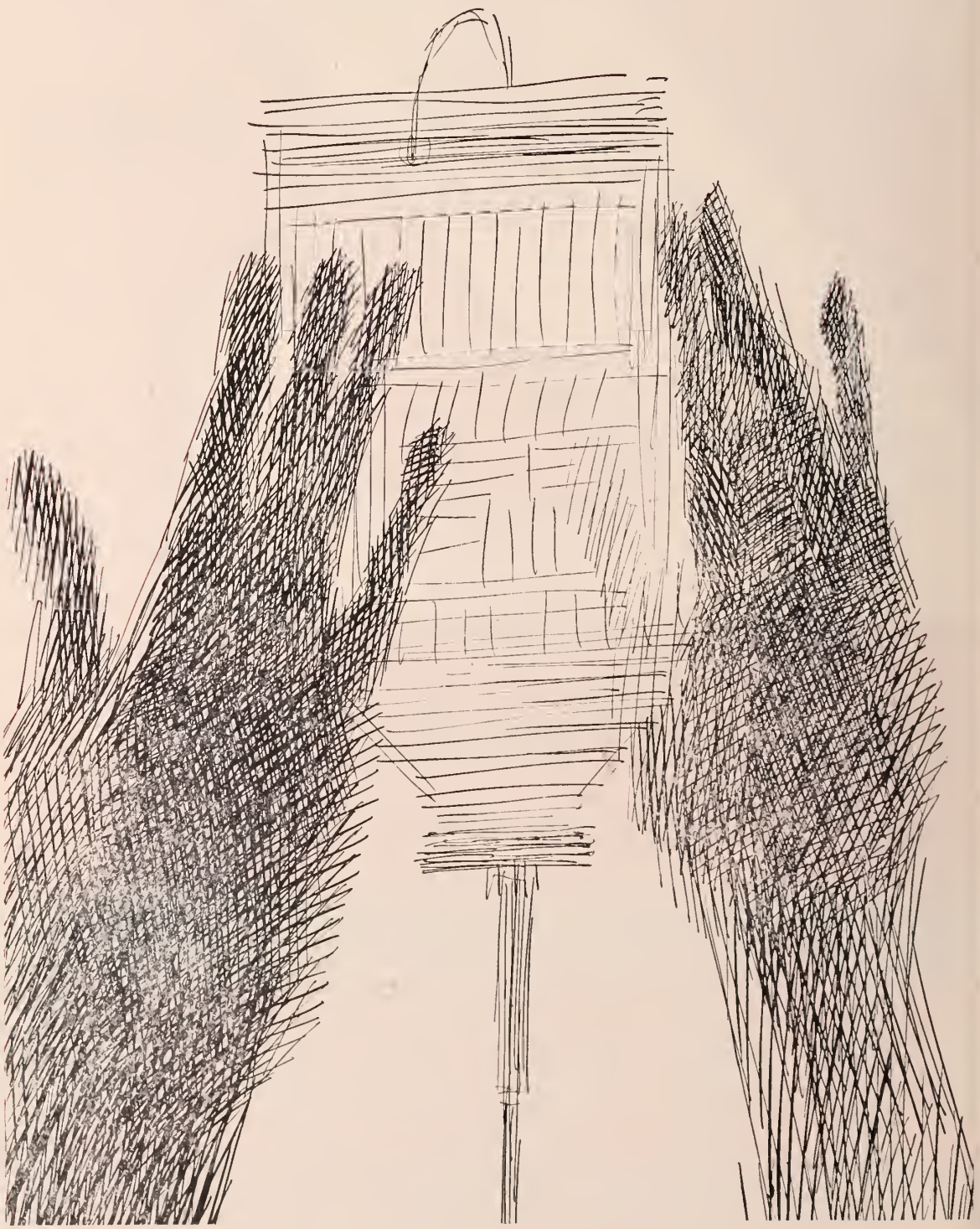
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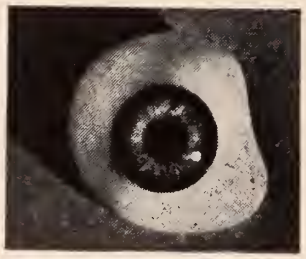
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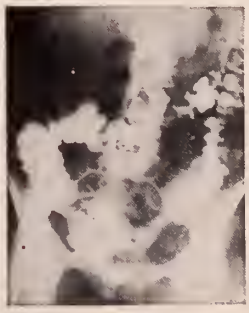
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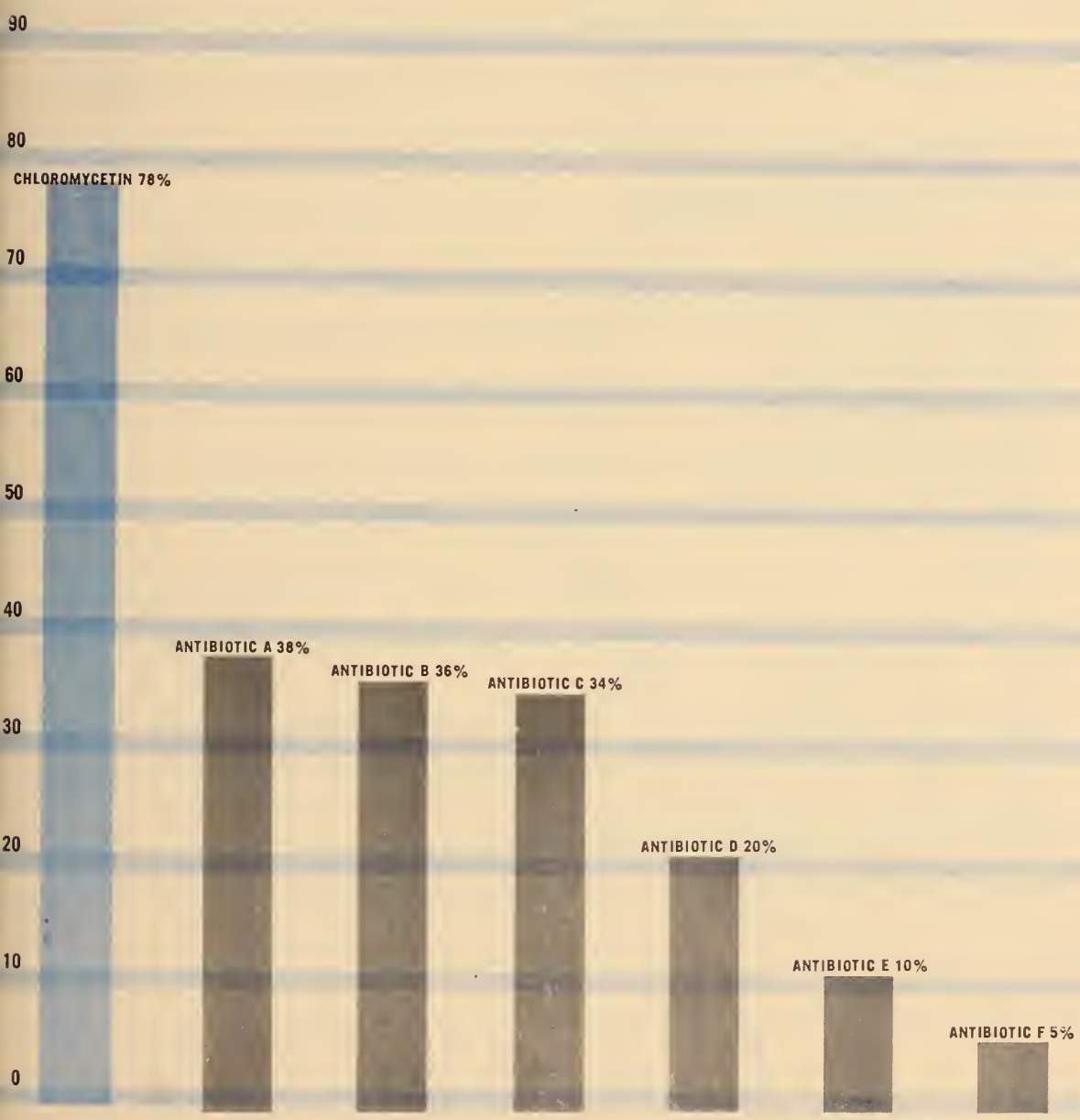
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Journal of the Medical Society of New Jersey (Suppl.)

The 191st Annual Meeting

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Haddon Hall, Atlantic City, New Jersey, April 27, 28, 29, 30 and May 1, 1957

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HOUSE OF DELEGATES
SESSION I

Saturday Afternoon, April 27, 1957

The 191st Annual Meeting of the House of Delegates of The Medical Society of New Jersey convened at Haddon Hall, Atlantic City, at 2:40 p.m., Dr. Louis C. Fritts, President of the Society, presiding.

President Fritts: The House of Delegates of the 191st Annual Meeting of The Medical Society of New Jersey is now in session.

The Reverend Gilbert Martin, of the Church of the Ascension of Atlantic City, will now present the invocation.

Reverend Martin: In the name of the Father and the Son and the Holy Ghost. Oh, Lord, Jesus Christ, look down from Thy throne in Heaven upon all these, Thy servants, here assembled, help them in their deliberations and conferences during this convention, bless them in their work, wherever they may be, guide them and guard them to continue the advances in medicine to Thy glory and the relief of mankind, comfort them when discouraged or sorrowful, raise them up if they fall, but above all in each of them a sure trust and confidence in Thy mercy. Through Jesus Christ, our Lord, Amen.

President Fritts: We will now organize the House of Delegates. Dr. Frank J. Hughes will give us the report of the Reference Committee on Credentials.

Dr. Hughes: All credentials are in order.

President Fritts: Thank you, Dr. Hughes. May I hear from the Secretary regarding a quorum?

Secretary Greifinger: Mr. President, a quorum is present.

(170 Delegates were registered at this point.)

President Fritts: Thank you, sir.

Mr. Robert M. Backes, the official Parliamentarian and legal counsel to The Medical Society of New Jersey, is on my immediate right. Will you stand up, Mr. Backes? (Applause)

Dr. Benjamin F. Lee of Camden and Dr. George A. Corio of Trenton will act as Sergeant-at-Arms.

Ladies and Gentlemen: It now becomes my privilege to give you an annual address, which is one of the duties of the President of The Medical Society of New Jersey.

Members of the House of Delegates: Two things impel me to address you briefly at this time: The By-Law which directs that the President shall deliver an address at the Annual Meeting, and the promptings of my heart.

The incoming President is characterized by curiosity and a certain vague fear — curiosity to know what lies ahead to be met and dealt with, and the vague fear that [illegible] satisfactorily [illegible] the responsibilities of his office.

The outgoing President [illegible] is [illegible] it seems to me, is characterized [illegible] [illegible] so quickly. [illegible]

[illegible]

With the increasing [illegible] of [illegible] [illegible] grows [illegible] has been a [illegible] society de- [illegible] coopera- [illegible] of wonder [illegible] of our [illegible] with the demands made upon them. Of one thing I am convinced: the days ahead will find pressures increasing but our attentions will not be diminishing. We are in for rather more than fewer complications. [illegible] con- [illegible] increase the number and efficiency of those who are to work in the service of medical [illegible] and medical progress. We must [illegible] profession who [illegible] the demands of their daily practices for medicine and the people the best that their talents can supply.

I urge each of you, as members of the House of Delegates, to assume a conscientious responsibility to do what you can to help medicine and our Society to do the work which must be done for survival and progress. Perhaps you can do more than you are doing. Perhaps you can win others to work with you

Thus far, thanks to the efforts that have been expended, we have managed to do a good job. Against the great external challenges that lie before us, I am calling for service and sacrifice in order that we may continue the good work.

Everywhere that I have turned throughout this year I have been impressed by the kindness shown to me. I shall not mention specific individuals lest by some mischance I neglect someone whom I would want to praise. Let me merely say for all the joys and satisfactions that have been mine, from my heart I thank you. (Applause)

I should now like to ask Dr. David Allman, who is the President-elect of the American Medical Association and who before very long will become its President, to come to the platform and address the House of Delegates. (Applause)

Dr. Allman: Thank you, Mr. President.

Officers of The Medical Society of New Jersey, Delegates, Physicians, Friends and Guests: I have no particular address to give you. I'm at home here; I'm one of you. I can, however, in my official capacity, officially welcome you and extend greetings to The Medical Society of New Jersey on this Annual Meeting. I hope that it will be successful in every way.

Whenever I am asked to welcome a state medical society or a state medical association, as some of them are called, I'm a little bit confused. In behalf of the A.M.A., I welcome you. But you *are* the A.M.A., and why should you be welcomed into your own organization? This group of people in New Jersey and similar groups in every other state are the ones that elect your representatives to the A.M.A. You in New Jersey have elected, I am happy to say, six very capable men and those six men go to the A.M.A. meetings and they determine the policy of the A.M.A. We officers have nothing to do with it. We simply endeavor, to the best of our ability, to carry out the dictates and the mandates of the House of Delegates of the American Medical Association. That American Medical Association is composed of your six delegates and the delegates representing every other state and territory in the Union.

I wish you would bear that in mind. You all know it, but sometimes you are prone to cuss the A.M.A. or say: why do they do that or why do they not do that? It's your fault that they do it and it's because of you they do not do it. If you don't like what they are doing, this Annual Meeting is the time for you to change it by changing your delegates to the A.M.A. Under the circumstances, of course, it would be crazy to do it because we have six fine representatives, but that's the way to change it. That's the way the A.M.A. works, as you all well know, but you don't think about it.

I just try to be a goodwill ambassador chasing around the country. I enunciate no policies. The policies that I enunciate are those previously determined by the A.M.A. House of Delegates, of which you are an integral part. I wish you'd bear that in mind when you think about criticizing the A.M.A. You are part of the A.M.A. You *are* the A.M.A. So don't start out after it unless your sails are clean.

We are always glad to see meetings like this. I have attended thirteen state meetings since I was elected President-elect last June, and we here in New Jersey—I've got my other hat on now; I'm a member of New Jersey—we don't have to take our hat off to anybody. Some of the state meetings are not all that we could hope that they would be. Some of them are very poorly attended. And I want to say for all of you who have anything to do with arranging our state meetings that our commercial exhibits are as good as any, our scientific exhibits are as good as any, our House of Delegates meetings are as business-like and run as efficiently as any that I have attended, and I feel very proud when I go around the country to think of these annual meetings that you hold each year in Atlantic City.

And that brings me up to the third hat I'm wearing and that is in behalf of the Medical Society of Atlantic County, as a Past-President, I want to welcome you to Atlantic City. I want to assure you that we are always happy to have you here. The facilities of our 160-odd members are at your disposal. If we can help you in any way, all you have to do is call upon any of us.

And the fourth and last hat that I am going to adorn is as a citizen of Atlantic City, who has been here for quite some time, I want to officially welcome you in behalf of the city.

The Mayor has given me, to present to you today, the key to the city, Mr. President, which symbolizes our welcome to you and gives you entré to most anything you want to get into. And knowing that you might get into trouble with that deal and knowing that you haven't got much longer to be our President, the Mayor also told me to give to our president-elect this official special detective badge, Number 371, so that in case with that key you do get into any mess you can't get out of, our

good friend Albert will get you out with this badge.

Thank you very much. (Applause)

PRESIDENT FRITTS: I would like to have the unanimous consent of the House to present a resolution.

DR. LANCE: I so move.

DR. KAUFMAN: I second it.

PRESIDENT FRITTS: Do I hear anybody opposed?

This is the resolution:

Whereas, our beloved member, David Bacharach Allman, has from his student days dedicated himself unreservedly to the profession of medicine and the welfare of his fellow-men; and

Whereas, in consequence of that dedication he is now universally recognized as a man of eminent stature and distinction; and

Whereas, by his election to the presidency of the American Medical Association he has received the highest honor within the power of American medicine to bestow and in so doing has reflected credit upon The Medical Society of New Jersey; therefore, be it

Resolved, that The Medical Society of New Jersey heartily acclaims him for his character and attainments and will ever hold him in prideful and affectionate regard.

I will now ask for a vote upon this resolution. All those in favor will signify by saying "Aye" and standing up.

(The Delegates arose and applauded.)

PRESIDENT FRITTS: In expectation of their approval of this, we have this for you, Dave, and I hope you will hang it upon your wall and cherish it. (Applause)

Dr. Allman: Thank you very much, Mr. President and members of this House of Delegates.

This is a complete surprise and certainly a very welcome one, with one slight element of disappointment. I thought I was a cog in this Medical Society of New Jersey. I'm a Delegate; I'm a member of the Board of Trustees; I attend the meetings and I thought I knew what was going on, and how this came about without my finding out about it, I don't know. (Laughter)

I greatly appreciate it. I accept it in all humility as a member of The Medical Society of New Jersey. In fact, I try to tell the people, as I go about the country, that I am no different from the five thousand other M.D.'s in New Jersey. We are all great fellows, and I'm just a symbol of each one of you. But it is amazing the respect and esteem that they have for the office of President-elect of the American Medical Association. I have received numerous resolutions and numerous plaques. Last night one was presented to me right here in this hotel by the Atlantic County Bar Association, for which I'm also grateful, because I think that building up better relationships with our allied groups, such as the Bar and Dental Associations and others will do American medicine much good in the future.

But I can honestly and truthfully say, Mr. President, that coming from you gentlemen who know me best, that this will always be closest to my heart, and I'm duly grateful. Thank you very much. (Applause)

PRESIDENT FRITTS: And now, Ladies and Gentlemen of the House of Delegates, I would like to have a temporary Speaker of the House appointed. To do this I must have your unanimous consent. I have selected Dr. Elton Lance, Past-President of the Society, to act as Speaker for the rest of this session and for two succeeding sessions, if you will support me in my wishes.

(Several Delegates made the motion and seconded it.)

PRESIDENT FRITTS: You have all heard the motion, and it has been seconded. Is there any discussion? If I hear no opposition, Dr. Lance will now act as temporary Speaker of the House for the rest of this session and for the second and third sessions. Thank you very much. (Applause)

SPEAKER LANCE: I am not going to make any extended speech except to express to Dr. Fritts my personal gratitude for having conferred upon me this honor, and also to you gentlemen who have supported him and who are willing to let me act as his mouthpiece during these sessions of the House of Delegates. We will try to conduct the business of the meetings as expeditiously as we can.

There is one announcement that might be of interest to you. On pages 52, 53 and 54 of your program you will see listed the personnel of the reference committees. That is something which you would like to know.

The next order of business is always a pleasurable one for this Society, and that is the introduction of delegates from other societies.

We are fortunate in having here Delegates from the Medical Society of the State of New York, and I wonder if Dr. James Greenough, its President, would come up. (Applause)

DR. JAMES GREENOUGH: Mr. President, Mr. Speaker, Officers, Delegates and Guests: As President of the Medical Society of the State of New York, I have the pleasant duty of bringing you the greetings of our 24,000 physician-members. Permit me also to add my

personal best wishes for your success at this important session and to thank you for the opportunity of speaking to you at your 191st Annual Meeting.

It is most appropriate that I should appear before you today as a representative of our State Medical Society. As practicing physicians in adjacent states, we have, of necessity, many medical problems of a similar nature. A large part of each of our states forms a principal segment of the New York metropolitan area. Many of your members treat patients who live in New Jersey, but work in New York. Many take care of New York residents who have positions in New Jersey. In a similar sense, our members look after New Yorkers who labor in Jersey and Jersevites who come to New York. Last, but not least, many New York physicians are participating in the fine scientific program you have arranged for this meeting.

Last September, on the western side of the Hudson River which separates our two states, a great step forward in medical history was taken. It was the opening of the new Seton Hall University School of Medicine and Dentistry. From this institution will come physicians and dentists who, I am sure, will help greatly in developing the constantly improving high standards of medical care by serving the people of both of our states. This project clearly shows that you, the members of the medical profession practicing in New Jersey, are not content to rest on past laurels but are keeping abreast of the times as well as building for the future.

In the past our two Societies have worked together from time to time. Today, however, and perhaps even more so in the future, I feel that a strong spirit of *continuing* active cooperation between our groups is most necessary. The modern practice of medicine is not limited to the realm of science. Medical economics and public relations fields have become an integral part of practice. Many of the problems that arise in these areas are not restricted by state boundaries. The new "Medicare" program for military dependents sponsored by the federal government, negotiations with organized labor unions and the ever present threat of socialized medicine, for example, are only some of the many fields in which cooperative efforts might prove mutually advantageous. A closer liaison between our Societies, working closely with the American Medical Association, will do much to advance the cause of medicine.

Speaking of the American Medical Association, allow me, personally and on behalf of our members, to congratulate one of your most distinguished members, Dr. David B. Allman, of Atlantic City, upon his selection as President-elect of our national organization. You should be particularly proud of the fact that he will be the first physician from New Jersey to hold this high office. And now I take my leave by expressing the hope that the decisions made here will produce new honors for The Medical Society of New Jersey and greater health services for the people of your great state. (Applause)

Speaker Lance: Thank you very much, Dr. Greenough. It's always a pleasure as well as an honor to have you gentlemen here.

We also have Dr. Gerald Dorman from the State of New York. Dr. Dorman, would you say a few words?

Dr. Gerald D. Dorman: Last month I was in West Germany as a guest of the West German Government, and in the course of our meetings with some of the professional societies over there they told the story of the overweight man who came in to see his physician. The doctor told him that he'd have to take off at least five pounds and he could do that on the first sitting. He told him to go into the examinging room and strip down, which he did. About the time he was ready for the examination, in came a very good looking nurse and she let an examining robe drop from her shoulders, and he stopped over to speak to her and she sort of retreated, went through the door into what appeared to be a gymnasium. And as he approached, she took off. He took off after her, up and over various obstacles; ended up by chasing her around sort of an indoor track until finally he fell exhausted on his face. She disappeared, and two men with a litter carried him back into the doctor's office.

He complained bitterly about this treatment, and the doctor said, "I guaranteed to take off five pounds. Get on the scales." He got on the scales, and he lost five pounds. So he paid his fee and left.

He got talking about this, after he got outside, and told one of his friends. The friend also went in for a treatment. He went through the same procedure, but when he got undressed and got in the examining room, in came an older woman, markedly overweight, a terrifically ugly face; and as she started to approach him, he backed away. The only escape was through the door into the gymnasium, with her after him. At the end of the exercise, he fell flat on his face and was drawn back, on the litter, into the doctor's office. He, also, had lost five pounds. The doctor said that this was exactly what the bargain was. The patient replied:

"Yes, but my friend had a very different experience." He said, "Well, after all, he was a private patient and you are on State insurance." (Laughter)

Our friends in the German Medical Association said, "Whatever you do when you get back to the states, take the message to them that in union there is strength and be sure that your component people support your medical association on a national scale."

I am here as a representative of New York State. I also have a second hat, which is the Chairman of Local Arrangements for the A.M.A. in New York City in June. I want to give each of you a cordial invitation, aside from your Delegates, to be present at that meeting. The scientific exhibits and most of the meetings are at the New York Coliseum. I would like to invite you to be present on Tuesday night, June 4, which is the night of the inauguration of the new President of the A.M.A., a man by the name of Dave Allman. Some of you may have known him. That will be the night he is inaugurated. There will be a reception after it in the Waldorf and we are looking forward to a good turnout. I want to personally invite each and every one of you to be there.

It's been a pleasure to be here and to speak to you and to see you. (Applause)

SPEAKER LANCE: Thank you very much, Dr. Dorman, for not only your invitation, but for your good advice. And now, Dr. Monahan from Connecticut.

DR. DAVID T. MONAHAN: It gives me great pleasure to extend the best wishes to The Medical Society of New Jersey from the Connecticut State Medical Society. (Applause)

SPEAKER LANCE: Thank you very much, Doctor.

I would like at this time to ask for a motion for approval of the *Transactions* of the 1956 Annual Meeting of the House of Delegates, which were published as a supplement to the September 1956 JOURNAL and have been distributed to the membership.

DR. KAUFMAN: I so move.

(The motion was seconded.)

SPEAKER LANCE: Is there any discussion? All those in favor say "Aye"; opposed, "No." So ordered.

I would like to request a motion that all reports from the April JOURNAL and those that are duplicated be referred to the designated reference committees. That only requires one motion and is standard procedure. Do I hear such a motion.

DR. KAUFMAN: I so move.

(The motion was seconded.)

SPEAKER LANCE: Is there any discussion? All those in favor will please say "Aye." Opposed? So ordered.

(See page 35 for the reports)

Are there any additional reports?

You will note in your folders that resolutions received are included in the envelopes distributed to the Delegates.

May I ask for a motion that these particular resolutions be referred to the reference committee to which they belong?

(Such a motion was made, seconded and passed.)

Are there any resolutions from the floor?

DR. ARTHUR BERNSTEIN (Essex): This resolution is from Essex County:

SOCIAL SECURITY FOR PHYSICIANS

"*Whereas*, the medical profession is now the only profession not covered by the present Social Security law; and

"*Whereas*, the Essex County Medical Society recently sent out 1,560 social security membership questionnaires which stated: 'Do you want compulsory social security? Yes or No'; and

"*Whereas*, 996 of our members returned this questionnaire, with the result that 677 were in favor of compulsory social security, and 319 against it; and

"*Whereas*, the results of this poll were forwarded to the Board of Trustees of The Medical Society of New Jersey, where no further action was taken on this matter because there is nothing pending in Congress at this time regarding social security; therefore, be it

"*Resolved*, that The Medical Society of New Jersey request that the other county societies poll their membership on the same question: 'Do you want compulsory social security? Yes or No', to determine their present thinking on the matter; and be it further

"*Resolved*, that if the other counties are now in favor of compulsory social security, that the New Jersey Delegates to the American Medical Association be instructed to take this matter before the House of Delegates of the American Medical Association."

SPEAKER LANCE: This will be referred to Reference Committee "E." Any other resolutions?

DR. IRVING LERMAN (Union): I am Irving Lerman of the Union County Medical Society.

The following resolution is proposed for your consideration:

POLICIES OF MEDICAL-SURGICAL PLAN

"In view of the widespread discontent among our membership with the fees paid and many of the policies of the management of the Medical-Surgical Plan of New Jersey; be it

"*Resolved*, that the policies of the Plan be very thoroughly reviewed by a committee of eight, to

be appointed by the President from this House of Delegates, such committee not to include more than two members of the current Board of Trustees of Medical-Surgical Plan; and that a report with recommendations be brought in to the Board of Trustees no later than December 1, 1957, for transmittal to the component medical societies."

Speaker Lance: Thank you, Dr. Lerman. That will be referred to Reference Committee "C." Any others?

Dr. Henry A. Brodkin (Essex): Members of the House of Delegates: I offer the following:

DISABILITY DETERMINATION UNDER SOCIAL SECURITY

"Whereas, now that the 1956 amendments of the Social Security Act have lowered the age limit from 64 to 60 years of age and thereby have increased the responsibilities of physicians who are requested to submit medical evidence of permanent and total disability to the State office of OASI by their patients who have applied for benefits; and

"Whereas, frequently in questionable cases, physicians feel the necessity for a more objective opinion without prejudice and avoiding a threat to a long established physician-patient relationship; and

"Whereas, the medical profession of New Jersey desires to assist its member physicians to render an accurate evaluation of applicants, and to cooperate with the State government agency to administer this act efficiently and justly; therefore, be it

"Resolved, that each county be instructed to establish a panel of physicians to whom such applicants may be referred by their physicians for a medical report to the Office of Disability Determination of the OASI that the applicant is or is not permanently and totally disabled and can no longer engage in remunerative employment."

Speaker Lance: Thank you, Doctor, That will be referred to Reference Committee "E."

Are there any other resolutions to be presented at this time? Any new amendments to the Constitution and By-Laws to be proposed? Is there any other new business at this time that anyone wishes to present?

The exhibits, which will be open on Monday morning are always worth visiting; not only that, but your visits encourage these people to return from year to year, and they assist us in developing this very fine meeting that we have each year. So I urge you all to visit the exhibits and sign your name, if you are asked to do so.

One thing that I neglected to do under the question of amendments to the Constitution and By-Laws is to ask for a motion to have the distribution of the printed revision constitute the first reading, rather than going through all this. Do I hear such a motion?

(Such a motion was made, seconded and passed. The Speaker called for additional new business, but none was offered. On motion, seconded and passed, the House adjourned at 3:25 p.m.)

SESSION II

Sunday Afternoon, April 28, 1957

The House of Delegates convened at 4:10 p.m., Dr. Lance, temporary Speaker of the House, presiding.

Speaker Lance: The meeting will please come to order.

May we hear a report from the Credentials Committee?

Dr. Hughes: All the credentials are in order.

Speaker Lance: Mr. Secretary, is a quorum present?

Secretary Greifinger: Mr. President, there is a quorum present.

Speaker Lance: Before we proceed to the business of receiving the report of the Nominating Committee, there is an announcement from Dr. Hurff.

Dr. Hurff: Mr. President, Members of the House of Delegates: As Chairman of the State Committee to the World Medical Association, I have been requested by Dr. Bauer, Secretary and Treasurer of the World Medical Association, to make a brief announcement in relation to this great organization.

Our President has emphasized the great necessity of eternal vigilance and interest on the part of the profession from the standpoint of the welfare of the county, the state and the national society. The same situation is true in relation to medicine throughout the world. The W.M.A. was founded about ten years ago, initiated, to the best of my recollection, by the American Medical Association and inspired by Dr. Louis Bauer and a few others.

It has grown to the point that we now have in America about 5,000 members, and in New Jersey approximately 230. The world membership represents 700,000 doctors, including 53 different nations. This is a most worthy cause. It deserves the support and interest of every doctor in America and the medical profession throughout the world. I assure you that if you read up on its activities and what it has done and what it is striving to do you will all say that it is a worthwhile organization.

I speak this afternoon to encourage all of you who feel like supporting medicine as individual doctors and as members of the medical profession to support the Worldwide Medical Association. The membership fee is $10 a year. Thank you. (Applause)

SPEAKER LANCE: Thank you, Dr. Hurff.

At this time it gives me a great deal of pleasure to introduce to you Dr. John W. Shirer, President-elect of the Medical Society of the State of Pennsylvania. Dr. Shirer. (Applause)

DR. JOHN W. SHIRER: Mr. President, Members of the House of Delegates of The Medical Society of New Jersey, Ladies and Gentlemen: I am a novice at this. Dr. Allman probably knows exactly how I feel.

I bring you the greetings of the Medical Society of the State of Pennsylvania.

I have had the opportunity of visiting several of the Reference Committees at work. My sincere sympathies go out to the chairmen of these meetings, especially Dr. Bowers. (Laughter)

No one can be employed in a situation of organized medicine without realizing the amount of effort, time and physical strength that are given to the management of organizations such as yours and mine. Just a year ago in this very room we had a reference committee on new business and this room was filled, and that was the open hearing.

Many problems that you have are similar to ours. The important phases of medicine today find themselves wrapped around the discussion of insurance plans, welfare funds and voluntary insurance, and third-party principles. The adjudication of these problems is not going to be done in one session; it's going to require a concerted effort not only of the House of Delegates, its officers, but every member in The Medical Society of New Jersey as well as my own. If we are willing to accept the principles that have been handed down to us, I feel sincerely we should protect them.

I will convey to my Board of Trustees and our Executive Committee, that the actions were so similar in committee meetings that I am sure that if this is continued over the entire United States and provinces, that we will have a solution to the problems of the basic practice of medicine. Thank you very much. (Applause)

SPEAKER LANCE: Thank you very much, Dr. Shirer.

I now ask for the report of the Chairman of the Nominating Committee, Dr. Vincent Butler.

DR. BUTLER: Mr. President, Mr. Speaker: The Nominating Committee met last night and made the following nominations:

Of course, the President-elect automatically becomes the President.

The nomination for President-elect for a term of one year, from May 1957 to May 1958, Dr. Kenneth E. Gardner of Essex County.

(Dr. Butler then read the names of the nominees.)

DR. BUTLER: There was a vacancy for a member of the Publication Committee and at the outset of the meeting a letter was addressed to the Chairman of the Nominating Committee by the Secretary of the Board of Trustees, forwarding a letter from Dr. J. Lawrence Evans, Jr. of Bergen County, who had been Chairman of the Publication Committee. Dr. Evans said that he did not wish to continue as chairman of that committee. His term was expiring and Dr. Evans asked that he not be renominated. Our Committee understood its function then was to nominate a candidate for chairman. Actually, however, our duty was simply to nominate a candidate for membership on the Publication Committee. The point is, as we later discovered, the President of the Society designates which member of the committee will be chairman. The House elects members to the committee. Thus we have not given you a candidate for the vacancy and it will be up to this House to select a member of the Publication Committee.

SPEAKER LANCE: Thank you very much, Dr. Butler.

President-elect for one year is Dr. Kenneth E. Gardner. Do I hear any other nominations?

(It was moved and seconded that the nominations be closed.)

SPEAKER LANCE: It has been regularly moved and seconded that the nominations be closed and the Secretary cast a ballot for Kenneth E. Gardner. All those in favor say "Aye." Opposed? So ordered.

(Upon motions duly made, seconded and carried, the remaining nominees were elected to the various offices up to and including New York Alternate.)

SPEAKER LANCE: To the State of Connecticut, for one year, Dr. Beckwell Sawyer. Do I hear any other nominations?

DR. TAYLOR (Passaic): Dr. Sawyer has asked that his name be withdrawn, and I would like to nominate Dr. Lloyd Hamilton in his stead.

(The motion was seconded.)

SPEAKER LANCE: The name of Dr. Lloyd Hamilton has been placed in nomination. Are there any other nominations?

(Moved and seconded that the nominations be closed.)

SPEAKER LANCE: Is there any discussion? All those in favor say "Aye." Opposed? It is so ordered.

Alternate to Connecticut, one year, Dr. Hamilton. Do I hear any other nominations?

(Moved and seconded that the nominations be closed.)

SPEAKER LANCE: Is there any discussion? All those in favor say "Aye." Opposed? It is so ordered.

Standing Committee, Committee on Publication, Dr. Corio.

DR. CORIO (Mercer): I'm Dr. Corio of Mercer County, a member of the State Nominating Committee. At this time I place in nomination the name of Dr. Fred Rogers, a member of the Mercer County Medical Society, who, in my opinion and the opinion of our Society, is well qualified to fill the duties of this position. He is at present the Editor of the Transactions and Studies of the College of Physicians of Philadelphia; he has written many articles, both scientific and historical, and is at present the Historian of the State Society. I place his name in nomination for the vacancy on the Publication Committee.

SPEAKER LANCE: Thank you, Doctor.

Are there any other nominations?

(Moved and seconded that the nominations be closed.)

SPEAKER LANCE: Is there any discussion? All those in favor will please say "Aye." Opposed? It is so ordered.

(Upon motion, the meeting was adjourned at 4:30 p.m.)

REPORT OF THE NOMINATING COMMITTEE

Office	*Term*	*From*		*To*		*Nominee*
President-Elect	1 year	May	1957	May	1958	Kenneth E. Gardner
First Vice-President	1 year	May	1957	May	1958	F. Clyde Bowers
Second Vice-President	1 year	May	1957	May	1958	Jesse McCall
Secretary	1 year	May	1957	May	1958	Marcus H. Greifinger
Treasurer	1 year	May	1957	May	1958	Rudolph C. Schretzmann
Trustees						
1st District	5 years	May	1957	May	1962	Joseph P. Donnelly
2nd District	5 years	May	1957	May	1962	L. Samuel Sica
3rd District	5 years	May	1957	May	1962	Reuben L. Sharp
At Large	5 years	May	1957	May	1962	Ralph M. L. Buchanan
Councilors:						
2nd District	3 years	May	1957	May	1960	Emanuel M. Satulsky
3rd District	3 years	May	1957	May	1960	Daniel F. Featherston
A.M.A. Delegate	2 years	January	1958	December	1959	William F. Costello
	2 years	January	1958	December	1959	Ydrich C. Crowe
A.M.A. Alternate	2 years	January	1958	December	1959	Albert B. Kump
	2 years	January	1958	December	1959	Elton W. Lance
Delegate and Alternates to Other States:						
New York	1 year	1958	N. Y.	Meeting		William F. Costello
New York Alternate	1 year	1958	N. Y.	Meeting		Arthur H. Marvel
Connecticut	1 year	1958	Conn.	Meeting		Beckwell Sawyer
Connecticut Alternate	1 year	1958	Conn.	Meeting		Chester H. Timberlake
Nominating Committee						
Chairman	3 years	May	1957	May	1960	

Dr. Lloyd A. Hamilton was elected from the floor and elected.

SESSION III

Monday Morning, April 29, 1957

The House of Delegates convened at 10:05 a.m., Dr. Lance, Temporary Speaker of the House, presiding.

SPEAKER LANCE: The House will be in order. May we have a report from the Credentials Committee?

DR. HUGHES: All the credentials are in order.

SPEAKER LANCE: Dr. Greifinger, is there a quorum present?

SECRETARY GREIFINGER: Mr. Speaker, there is a quorum present.

SPEAKER LANCE: The first report to be received is that of Reference Committee "A," Dr. Mary Bacon, Chairman.

(Dr. Bacon read the report of Reference Committee "A," (See page 28) which was adopted, section by section, and as a whole, upon motions made and carried.)

SPEAKER LANCE: Thank you very much, indeed, Dr. Bacon, for a very fine report. (Applause) And now, Reference Committee "B." Dr. Costello.

(Dr. Costello read the report of Reference Committee "B" (See page 29) up to and including "Publication Committee," which portion was adopted, section by section, upon motions made and carried.)

DR. COSTELLO: "Medical Service Administration. The report of the Board of Trustees indicating a subsidy of $5,000 to Medical Service Administration was noted. The public relations value of this organization was again emphasized, and your Reference Committee approved this action of the Board of Trustees."

Mr. Speaker, I move the adoption of this portion of the report.

DR. MINEUR (Union): Mr. Speaker, I ask for a little elaboration on this deficit of $5,000. It it a recurring item?

DR. COSTELLO: The Committee was informed that this Medical Service Administration has been functioning and we all know it started as a farm program some years ago and that caused a deficit. They are now processing indigent care for the City of Newark. The financial condition of a great many of the working people of Newark, who were formerly on relief, has been alleviated and, naturally, returns from the processing of this plan have not been enough to pay the cost of the office. It has nothing to do with "Medicare." They are also processing "Medicare" claims but there is no deficit in respect to that.

DR. MINEUR: Then this is in effect a subsidy to the Newark welfare?

DR. COSTELLO: No, not a subsidy to the Newark welfare. The Newark Welfare Department is using our services, but we would still have Medical Service Administration function or at least in a position to function whether they were processing Newark's indigent plan or not.

DR. ROYAL A. SCHAAF (Essex): Mr. Speaker and Members of the House of Delegates: I would like to point out that while this contribution to the Medical Service Administration has been a recurring item for the last three years, for a number of years it was self-sustaining. We are self-sustaining when we have a depression and there is a demand for our services. We have paid out 10 per cent of the moneys we pay for servicing doctors. That is based on the total amount of money which is paid to the doctors. So when our income is low, it means that times are good. When our income is high, it means that times are bad. It is necessary to keep in being an agency such as the Medical Service Administration to deal with just such problems.

"Medicare" is neither a deficit nor a contribution to the funds of the Medical Service Administration; but had this not been in being, "Medicare" implementation would have been almost impossible. We could not have used the Hospital Service Plan's facilities directly for this purpose. It has to be done through an intermediary, so the existence of this body made it possible to carry out the "Medicare" program for physicians.

The expenditure of $5,000 a year may not be recurring, depending on circumstances. It is quite likely that following June 1 of this year, when the new provisions of the Old Age Benefit Program come into effect, that the Medical Service Administration will be requested to conduct this direct payment of physicians on behalf of the State government.

So that in any circumstances, we must keep the organization going. It's like a fire department which you don't use and hope you never do use, but you must have it to meet just such emergencies.

SPEAKER LANCE: Is there any further discussion? Are you ready for the question? All those in favor please say "Aye." Opposed? (There were several Noes.) The "Ayes" have it. So ordered.

DR. COSTELLO: "The Reference Committee wishes to express its appreciation to Dr. All-

man, Dr. McCall, and Mrs. Madden for their attendance at the meeting and for their assistance." And I personally, Mr. Speaker, would like to thank the members of the Committee who were very helpful in the preparation of this report.

Mr. Speaker, I move the adoption of the report as a whole.

(The motion was seconded.)

SPEAKER LANCE: Is there any discussion? All those in favor will please say "Aye." Opposed? (There was one "No.") So ordered.

Next is the report of Reference Committee "C." Dr. F. Clyde Bowers.

(Dr. Bowers read the report of Reference Committee "C" (See page 29) through "Medical-Surgical Plan Physician Lists," which portions of the report were adopted, section by section, upon motions made and carried.)

DR. BOWERS: "Indemnity Basis for Medical-Surgical Plan (from Union County). This resolution was disapproved by your Committee for the following reasons:

"A. Beyond the limits of a $5,000 single income and $7,500 combined income, the Medical-Surgical Plan becomes an indemnity plan.

"B. For the non-participating physician, it is in essence an indemnity plan.

"C. In this inflationary period, the $5,000 to $7,500 income group is a proper group to have in a service plan.

"D. And further, any effort to change our present Medical-Surgical Plan from a service type of plan to an indemnity type of plan would necessitate complete dissolution of our present Medical-Surgical Plan."

I move the adoption of this portion of the report.

(The motion was seconded.)

DR. CARL G. KAPP (Union): This problem had quite a little discussion before the Committee yesterday, and to clarify opinions on it and interpret our part, some explanation is needed.

Because of the general dissatisfaction with injustices and inequities of the Medical-Surgical Plan of New Jersey and misunderstandings created in the minds of patients and physicians, the members of the Union County Medical Society adopted on March 13, 1957, the following resolution. And I might say that there were no "Noes" that I heard in the approval of this resolution.

"It is felt that an indemnity plan especially protecting the low income group as originally considered and instigated by the Medical-Surgical Plan of New Jersey would maintain a better relationship between groups of physicians, and particularly between physicians and patients. Such a plan may even increase the enrollment of physicians in it and be a more practical approach to the problem.

"*Whereas*, the Medical-Surgical Plan of New Jersey was originally set up to take care of the low-waged and medically indigent groups on a minimum fee schedule on an inclusive fee basis; and,

"*Whereas*, the Plan has long ago departed from this principle and is selling this contract to a very large proportion of the entire population of the state, thereby fixing service benefits to physicians in the Plan regardless of the amount of service rendered by the physician; and

"*Whereas*, the present minimum fee schedule for the poor is fast becoming the maximum fee for the entire population and a standard by which other fee schedules are being set up; therefore, be it

"*Resolved*, that the Medical-Surgical Plan of New Jersey be placed on an indemnity basis under the present laws if legally possible. If it is not legally possible, The Medical Society of New Jersey and the Medical-Surgical Plan of New Jersey should be instructed to work to have the laws of New Jersey changed so that our Medical-Surgical Plan may be set up on an indemnity basis as soon as possible."

We wrote to find out what the rules were regarding insurance set-ups of this sort. The reply came from Mr. Byron Wright of the State Department of Banking and Insurance. He said—and this is quoted from Chapter 74 of the Laws of 1940—that any medical service corporation may classify subscribers whereby under specified circumstances a subscriber or covered dependents may pay a participating physician for medical services an amount in addition to that payable by the corporation for medical services. Now, that states specifically that the power rests with the governing body of the Plan.

It goes on to say that the subscription certificate issued to any subscriber so affected shall contain the provision therefor and specify such circumstances. To me that means that it has to be in the contract as to what level this may take place. So we use the terms probably indefinitely, sometimes confusedly whether it is a "service plan" or an "indemnity plan." In a way, they are all "indemnity plans," being a service plan apparently amounting to the fixation of the top level.

Now, yesterday quite a bit was said about top levels. We endeavored to show the increase in income among laboring groups. For example the national income has gone up in the last 30 years from 9 billion to 72 billion and we are still running at a deficit federally.

Above limits of $5,000 and $7,500 com-

bined, the Medical-Surgical Plan becomes an indemnity plan. However, these limits include 80 to 90 per cent of the people, so that you have anyone below this income in the "service" bracket. These incomes are from statistics only, obtained through the factory where they work. We cannot get necessary income data from outside investments except by asking the patient. Therefore, you have the Medical-Surgical Plan put in the position of having to determine income.

"For the non-participating physician, it is in essence an indemnity plan. In this inflationary period the $5,000 to $7,500 income group is a proper group to have in a service plan." That is fine except that this top level is far and above what it should be; and also we feel that the proportionate rise in income —and we have statistics to show you what that is—has been much more than it would warrant. In other words, starting out from idealism to help a low income group feel they have substantive medical care, and Lord knows, giving them clinical care otherwise, we have gone on to include most of the population.

"Any effort to change our present Medical-Surgical Plan from a service type of plan to an indemnity type of plan would necessitate complete dissolution of our present Medical-Surgical Plan."

Well, now, we worked without dissolution from a plan that originally gave $1,800 to $2,400 coverage when it was started in the idealistic days and when it was thought it could not be carried on because of low income, up to a $5,000 and $7,500 income. Why could we not work back? I see no reason why it could not be established in such a way that we could set a minimum.

In the discussion of this Plan we know that there is much dissension, in fact most of the testimony we listened to yesterday was that of dissension, inequities to doctors in the Plan, inequities to doctors out of the Plan. Some explanations seemed satisfactory, others we questioned. But there they were and wherever you go you hear the same argument.

Now, how far can that go on without internally disrupting your medical profession? The only alternative to a doctrine like this is a complete resignation of the separate county societies or groups as a whole. What does that do? You have then your medical society split in two parts—either you are in or you are out.

Right now insurance is being sold with the statement: if you want the benefits of our plan you should go to *our* physicians. That is an entering wedge for splitting the medical profession.

Now, we could go on a long time on ethical grounds, on grounds of patriotism and on grounds of what is right. We submit a few facts, and that is that only the doctor and the patient can know what his services are worth and how much true service he has given, and not some third party. Wherever you have a third party enter, the cost of service to the individual receiving it goes up and the dissatisfaction seems to increase. The third party always means more work, more cost and less satisfaction.

It had been said that these plans would cut down on the number of ward and clinic patients. It may have helped on the surgical side to some extent; but in medical services statistics from several hospitals show in spite of all these plans *the clinic load has increased.* In one, for example, in an overly populated area which could not admit too much more population, from 11,000 to 13,000; in another, from 7,000 to 13,000. So it has not "cured" this free clinic visit problem.

Government is fast approaching with new plans, new fees. So far as we know, these are not always submitted to county societies for the action or thought of the man who is affected by them. They are put in effect and the first thing you know you have a fee schedule without any consideration. It seems to me a revision of principle is necessary. Also, what has happened to the constitutional freedom of medical men? Have we the freedom to select a plan we like? You say we have, through our representatives; but we know sometimes it's coercion all along the line. Coercion is the thing that the medical profession ought to deplore.

Have you considered the amount of desk work and paper work on all these plans? It has added a great burden to the doctor. And in spite of some slight improvement of his fees, I wonder whether it is always worth it.

The ideal situation is a direct relationship with the patient. The doctor should have a right to fix the fees with the patient. Only in that way can you come to an honest conclusion and even a better relationship to patients.

I hope that some consideration will be given this. We realize that it is in the state of "ifs." We feel that something is going to have to be done about it and I think great consideration should be given and I believe now to save the plan. (Applause)

DR. SCHAAF: Mr. Speaker and Members of the House of Delegates: This subject was considered exhaustively yesterday. I mean exhaustively to the Committee and exhaustively to me. We have heard today a repeti-

tion of all the statements which were made yesterday, all of which we think we successfully controverted and which finally led the Committee to make the recommendation which they have this morning.

The difficulties that Dr. Kapp has stressed so, shall I say, eloquently, are non-existent in his case because he is a non-participating physician and has none of the restrictions. For his purposes, this is an "indemnity" plan to begin with.

If one thinks of the philosophy of the Blue Shield movement, one realizes that it must be a "service benefit" program. If it is not a service benefit program, there is no excuse for doctors to operate an insurance plan because if it were a strict "indemnity" plan the commercial insurance companies, with their skill and resources, would do a better job than we could.

Now, the allegation seems to be that the income limit has risen and that the fees have remained static and that there is an increasing proportion of the population which is coming under the "service benefit" provisions of the contract. Well, that is not true. In 1944, there was a $2,000 limit for individuals; there was a $2,400 limit for a husband and wife, and there was $250 additional without limit to the number of children. With that we had a relatively low schedule of benefits. An appendectomy was $100.00.

In the 1949 contract we raised the income level to $5,000, but we made a very substantial increase in the schedule of benefits proportionate to it.

In 1942 about 80 per cent of the people of the state, plus or minus one per cent, were included in the "service benefit" possibilities. In 1944 there were 80 per cent of the people, plus or minus one per cent, who were eligible for "service benefits." In 1949, some 80 per cent of the people, plus or minus one per cent, were eligible for benefits. In 1956, about 80 per cent of the people, plus or minus one per cent, were eligible for service benefits.

Gastrectomies in 1942 were about $175 and they have been increased each time until presently they are $300. We have expanded medical benefits; we have expanded out-patient surgery; we have expanded many things.

Legally, if we were to convert our medical-surgical plan into an "indemnity" plan, as opposed to a "service benefit" plan, it could be accomplished only by the dissolution of the present organization and reorganization of a new corporation which would then function under the general insurance laws of the state.

And I submit, ladies and gentlemen, that Dr. Kapp's complaints from his own point of view are quite unjustified. I don't think that it is possible to reduce the amount of clerical work connected with the satisfactory filling out of a claim blank. That work can be done in thirty seconds.

I think his complaint is that in the case of non-participation by a physician we pay the subscriber and then the physician might occasionally have a little difficulty getting that fee. But that is the same difficulty that applies in most commercial insurance transactions. If payment is made by assignment, we require the signature of the subscriber as well as the signature of the doctor. We do that for the reason that we have a contract with the subscriber and we have to be satisfied that the subscriber is satisfied that we have lived up to our obligation. And there are other less important legal reasons for doing it.

This organization is under the strictest scrutiny by the Department of Banking and Insurance. We are much more limited in what we can do in a contract than a commercial company is. As a non-profit organization we are tax exempt and therefore we are in the nature of a public utility. And up until now when the Banking Department has refused to let us do something, they have justified it by what is cogent reasoning.

For example, we tried for some time to get a double level of contract with a higher income limit and a higher schedule of benefits. We approached them with a proposal for $7,500 and $15,000, with a sharp differential. Their immediate response was: doctor, you can't convince us by any line of argument that there is justification for a differential in price for the same service. Now, they say: if you are willing to talk on the basis of a single price at a single level, we'll consider that; but we won't consider the two-level contract. It's not too material to us what your contract level is and what your schedule of benefits is, but whatever it is it must apply in all circumstances in an exactly similar manner.

Therefore, Mr. Chairman, I urge that the Delegates sustain the recommendation of Reference Committee "C" in the matter of changing from a service benefit program to an indemnity plan. (Applause)

DR. E. MILTON STAUB (Union): This Medical-Surgical Plan, brought into being by the physicians, should be supported by all the physicians. However, some of us have had to withdraw because the inequities were greater than we could approve of; yet seemingly we had no voice in the actual management of the Plan itself.

Dr. Schaaf has shown us how the ceilings have increased by 300 per cent, but he failed

to show with equal enthusiasm that the increase in the amount of compensation to the physician increased, in the example of the appendectomy, only 25 per cent. He also failed to show that in gastrectomies the increase was less than 100 per cent and yet the ceilings were increased 300 per cent.

Pertinent to this discussion is a quotation which appeared in the April 1957 *Medical Economics*. This is on Page 84 and it's entitled "Why Cut-rate Fees?" "According to a recent study, 36 major industries now pay their average worker at a rate of more than $5,000 a year." The text says: "Labor leaders are very much aware of this income revolution, but some medical leaders don't seem to be. As members of the governing boards of the Blue Shield Plans, they continue to offer medical-surgical insurance whose benefits and income ceilings and fee schedules still smack of the Great Depression. This is unfair to doctors and patients alike, and other medical leaders are beginning to say so.

"Listen, for example, to Dr. Samuel B. Haddon, President of the Philadelphia County Medical Society: 'Our Blue Shield Plan has at times set fee scales that are hilariously unrealistic. They are especially unfair to those who practice in the medical specialties.' Why have we permitted the planners to set fee scales so far below the prevailing rates? As Dr. Haddon says: 'Knowing labor men as I have all my life, I do not believe that any individual who earns his livelihood by the sweat of his brow feels that a physician should be called upon to accept fees lower than his usual rates because he is participating in a prepaid medical plan. The plumber, the electrician, the carpenter or the plasterer doesn't reduce his hourly rates because he is working on a house which will sell for $10,000 rather than one that sells for $50,000. I do not believe that any labor leader or any laboring man in the United States wants a physician to be forced to work at scab rates. Physicians are working at scab rates for some Blue Shield plans. They have the power to change this and they may have an unsuspected ally in labor. The least they can do is to find out locally."

The average physician, knowing his patient as he does, is much better able to judge the circumstances under which that patient is having to meet his financial obligations, and I firmly believe that it should not rest entirely on the basis of income itself. Many families have obligations such as care of parents, such as undue sickness, and so forth, and the physician can make his adjustments accordingly. I firmly believe that an indemnity plan is the only fair type of plan to the physician and to the patient alike. (Applause)

Speaker Lance: Members of the House: I call your attention to Section 4 of our By-Laws: "No address or paper, with the exception of those delivered by the President, President-Elect, and invited orators, shall occupy more than twenty minutes in its delivery or reading; and no member shall speak longer than five minutes, nor more than once, on any subject, unless by permission of the society."

What is your wish in reference to this type of debate? Do you wish to give them unlimited time? Shall I recognize a speaker more than once?

Dr. Schaaf: Mr. Chairman, I think that in certain circumstances it might be necessary for the same speaker to speak twice. For example, when allegations are made about the inadequacy of Blue Shield, I, as President of the Plan, am perhaps in the best position to answer the particular allegation. We have other members of the Board here and I would be very glad to adhere to a ruling and call on each member to take a shot at the response, but a good deal of time and effort — after all, we had been through this yesterday and I have been through it every other year and I think that we have had answers. I would hate to subject members of our Board to the same kind of harassment that I have been subjected to for the last four or five years.

Dr. Gannon: I make a motion that debate be limited to five minutes but that persons be allowed to talk more than once.

(The motion was seconded and carried unanimously)

Dr. Joseph P. Donnelly (Hudson): Mr. Chairman, this debate has been going on, as you know, all day yesterday. We have heard from Union County which, historically speaking, was, I believe, the last county to join the Medical-Surgical Plan. I am not surprised that they are even now not in favor of it.

It has been said that there is a great dissent throughout the state against the Medical-Surgical Plan. The fact remains that between 80 and 90 per cent of the physicians throughout New Jersey are participating members of the Medical-Surgical Plan and are willing to give service benefits to these people in this great $5,000 to $7,500 income level.

I don't know what any of your budgets are, but I can assure you that anybody making five or six thousand dollars a year, which is the average family income under this Plan, has plenty of difficulty in meeting his honorable medical expenses; and while you may talk

greatly about the 20 per cent of the people from whom you could extract another $25 for an appendectomy, I assure you, gentlemen, there are 20 or 30 per cent of your patients who would not pay you at all unless they were covered under the Medical-Surgical Plan.

It has been said in Union County there were no dissents. In many county society meetings there are plenty of people who are afraid to stand up and be counted because the county society meetings are also attended by people who have much to say about hospital medical boards and appointments on hospital staffs in those counties. (Applause) It is very strange to see that with no dissent in Union County there are still so many participating physicians in this Plan.

I think, gentlemen, that the times have changed; the times are good. We are all making a good living; there is no doubt about that. You are all down here enjoying yourselves. This is not the 1930's when this Plan was started. If we had a depression, you would again begin to wonder about how many of these people were covered, and while at the present time you might be getting a little bit less than the last dollar you could extract from a patient, this is the greatest cushion you ever had against the depression which may come at any time and which some of our leaders are already stating may be on the way.

I will just close by reading something which was said here early in the report of the President and I think it is time for us all to think this over, that the purpose of The Medical Society of New Jersey and of the Medical-Surgical Plan is not to take care of the physicians throughout New Jersey, but give the best possible care to the people of New Jersey.

I close by reading from the report of the President: "We need men and women who in their daily practice will deal with their patients not only so efficiently but so intelligently and compassionately that they will make each patient a stalwart admirer of the entire profession. We need men and women of such character and worth that each will be an influence for better public relations with all his patients. In short, we need men and women who love medicine and their fellowmen, and who serve what they love unselfishly."

Maybe that is just a little window dressing which we start the meeting out with. I think it is something which we should close the meeting with. Thank you. (Applause)

DR. KAPP: Mr. Chairman, Ladies and Gentlemen: I want to apologize for taking the floor again, but I think there are some things I have to straighten out. One is about not belonging to the Plan. We don't belong because we didn't feel it was equitable to the doctors in every way, not only because of the monetary principle. We deplore that what has been stressed so much is the dollar value of this Plan. I agree with the last speaker that it should be above that level, and we practice above that level.

Now as to my speaking, not being a participating member. It was not my seeking, sir. I'm trying to do a duty to Union County as I was appointed to do.

The purchasing income in 1939 — $5,000 would purchase then what $10,400 will purchase now. An income of $25,000 in 1939 will require the equivalent of $69,000 to meet the current purchasing power. These facts pertain not only to the medical profession, but every one in the country. We submit on this financial business that the level of increase in fees, if you want to put it on a financial basis, cannot in any spiraling inflation keep step with the demands each year of increased wage earnings. We can go into the details and show you how steel labor has increased 300 per cent in the last 15 years.

There is a question that goes beyond this income business. One is the adequate and proper care of people medically, and I think we always do that; we always have. Come depression, whether they can pay premiums for insurance or not, we are going to take care of them. Our case load in our clinics and those I'm associated with has not decreased; it's increased in spite of all socialization plans.

Sociologically we have copied after some plans tried in other countries — the Keynes Plan for Britain, for example. Recently Keynes admitted that he was wrong in his sociologic thinking. It has gotten to a point in that country where a few weeks ago we were notified in the newspaper that British physicians may have to go on strike. I don't want to see American medicine get that way.

Fundamentally, what does it do for an American individual? Does it teach him to be self-sufficient? In the Army, in any athletic endeavor we take these boys and train them for months to make themselves sufficiently self-dependent, have pride and take care of themselves. What are you doing by increasing plans? Covering everybody. Is that socialization? To my way, it's a sure step forward, and I hope you give it some consideration. (Applause)

DR. SCHAAF: In the early days we had a gentlemen's agreement with The Medical Society of New Jersey and with our component societies that we would not try to operate

Medical-Surgical Plan in any county unless we had the formal endorsement of that county. Slowly but steadily we secured the endorsement of all but Union County, but we were bound by the gentlemen's agreement.

Dr. Londrigan, who was then President of the Society, and Dr. Norton, who was Chairman of the Board, asked for the privilege of appearing before the Union County Medical Society. They were permitted to appear. But the then President of the Union County society did not recognize their presence; they were completely ignored, so that no opportunity was given to the Medical Society's emissaries to present this problem. So Dr. Londrigan and Dr. Norton left the meeting, having been satisfied that they were not to be heard, and they came back to the Board of Trustees. By this time the year 1945 had arrived and we were unable as a plan to operate throughout the State of New Jersey with state-wide industries because we were limited. At that time there were 435 members of the Union County Medical Society. A decision *not* to approve the Medical-Surgical Plan of New Jersey was made at a meeting at which there were 42 members present. About 23 of those members voted against the Plan and 19 voted for it. By a majority of four out of a meeting of 42, less than 10 per cent of the society, the whole program was stymied. At that point the Board of Trustees of The Medical Society of New Jersey abrogated the agreement. But then we operated on a state-wide basis. At that time we actually had 400 participating physicians in Union County, although we were unable to operate there.

Now, curiously, the same men who recently had been voicing the objection of Union County have been speaking against this whole business—it's the same story that we have heard in 1941, 1942, 1943, 1944, 1945 and ever since.

Now, I'm sure that this mandate, which is directly repeating Dr. Kapp, to speak for Union County was taken at a relatively small meeting from the standpoint of attendance and it probably is a situation similar to what obtained in 1945 when by a vote of two or three in a very small attendance of less than 10 per cent this whole business was stymied, and I think it is time, gentlemen, that we put the quietus on this type of objection for non-participating physicians. (Applause)

SPEAKER LANCE: Is there any further discussion?

The motion is to approve this portion of the report. All in favor say "Aye." All those opposed? The "Ayes" have it.

(Dr. Bowers then read the remainder of the Committee's report, which was adopted, section by section and as a whole, by appropriate motions.)

SPEAKER LANCE: Dr. Bowers, we do commend you and you did a beautiful job, and we thank you very much. (Applause) I now call on Reference Committee "D." Dr. George E. Barbour.

(Dr. Barbour read the Committee's report (See page 31) through "Medical Education," which was adopted section by section.)

DR. BARBOUR: "Emergency Medical Service, Civil Defense. The Reference Committee unanimously approved the report of the Special Committee on Emergency Medical Service, Civil Defense, and commends the Committee for the time and effort given this subject."

Mr. Speaker, I move the adoption of this portion of the report.

(The motion was seconded.)

DR. CHARLES E. JAECKLE (Essex): Mr. Speaker and members of the House: I wish to discuss a portion of the Emergency Medical Service, Civil Defense report dealing with Objective Number 1 under Other Activities, and I quote:

"The following objectives are proposed by the Committee for realization in the near future: (1) the sponsorship of an Advisory Council on Emergency Medical Services, Civil Defense by The Medical Society of New Jersey and the offer of the State Society headquarters as a meeting place.

"*Composition*: This Council should include representatives from all relevant groups including nurses, osteopaths, chiropractors, veterinarians, dentists, first aid squads, et cetera."

Such a Council, I feel, should not include "Chiropractors and et cetera." Now, I was a member on a panel on Civil Defense in the A.M.A. conference on Civil Defense in June 1956, serving because of my position as Chairman of the Subcommittee on Civil Defense of the Section on Ophthalmology of the A.M.A. The recommendations of the subcommittee were approved by the Council on Civil Defense of the A.M.A.

At the 1956 Civil Defense conference I learned from the Medical Administrator of the Federal Civil Defense Administration, their policy in the matter of chiropractors and optometrists who might be considered under "et cetera." That policy is that the chiropractor and the optometrist do *not* have a part in medical service and they are excluded from the planning for medical services by the federal administration. Even though the A.M.A.

has not granted recognition to the osteopath, the law does in New Jersey. Even though we recognize him as licensed to practice medicine, the chiropractor is not recognized anywhere in the capacity in which he presents himself. The same is applicable to optometrists.

Chiropractors have approached Federal Civil Defense and have been advised to take first aid courses and referred to local authorities.

Optometrists contemplate for themselves the role of handling the eye casualties. In this state they issue press releases reporting that they are taking courses on how to handle eye casualties. They have published a plan for emergency "eye stations" which would first receive all eye cases. These would be manned by optometrists.

The Council on Civil Defense has accepted the principle that medical services in eye cases must be rendered by personnel directly affiliated with medicine, and optometrists will not fill that role. They have no special training by virtue of which they can make a special contribution in this field.

I have made some personal references to my capacities in medicine, which I felt were essential to qualify my making the statements I have made. I'll make one more personal reference. I am Past-President of the Optometry Alumni Association of Students of Optometry of Columbia University, which no longer teaches optometry because optometry has moved to the status of irregular practitioners. (Applause)

DR. R. WINFIELD BETTS, (Burlington): I'm the Chairman of the Special Committee on Emergency Medical Service, Civil Defense.

It seems to me better that we have the optometrists, the nurses, the veterinarians, the chiropractors, the first aid squads, the Red Cross, all of the associated or allied medical facilities in a group and get the benefit of their advice and to have them talk with us than it does to keep them out completely.

I went to a conference with the Governor and heard General Cantwell castigate the physicians of this state. He said that you cannot get doctors to take the job of medical directors in the communities. He said we have to give those jobs to chiropractors and osteopaths. If no physicians are willing to take the job of medical directors of communities and if these other men *are* willing to step forward, the state is going to use them. It is better that we take them in the fold and get the benefit of their advice and control them before they put us in the position of the tail wagging the dog.

We are the medical men in the state and we should be the ones who control the practice of medicine and we should be the ones who would give the Governor and his staff advice as far as medical care is concerned.

We are not going to sleep with these people. All we are going to do is to take their advice, put them on a committee and listen to what they have to say. If they have something good, let us take it. If they don't have anything good, we don't have to act upon it. That's all. (Applause)

DR. HURFF (Essex): The problem here is, should these respective groups be placed on the Council? Their services may be utilized if in the judgment of the medical profession and the judgment of the nursing profession and the osteopaths, so on, and they are needed they can be utilized. But the question here is, should they be put on the Council in an advisory capacity?

DR. JAECKLE: I move to amend the report by deleting therefrom the words; "chiropractors" and "et cetera."

This amendment was seconded and passed. On motion, made and seconded the "Civil Defense" section of the report, as amended, was adopted.

Dr. Barbour then read the remainder of the Committee's report, which was adopted, section by section, and as a whole, as amended, by appropriate motions.

SPEAKER LANCE: We thank you very much, Dr. Barbour, for a good job well done. (Applause) Now, we hear the report of Reference Committee "E." Dr. Rudolph C. Schretzmann.

(Dr. Schretzmann read the report of Reference Committee "E" (See page 31) through "English as a Factor for Medical Licensure," which portion of the report was adopted section by section.)

(Dr. Schretzmann then read "Disability Determinations Under Social Security.")

DR. SCHRETZMANN: Mr. Speaker, I move the adoption of this portion of the report.

(The motion was seconded.)

DR. HENRY J. MINEUR (Union): We have a principle involved in this that we should consider a little more carefully. Let me quote a line from Mr. Nevin's report: "These are days to try the mettle of Medicine as a profession, and of physicians as individuals. We must stand and work together, within the framework of our Society's structure, to preserve the best that we have—for our fellow citizens and ourselves—and to resist the deleterious and unwholesome changes that our adversaries would thrust upon us."

This is going to be a tough question for the

physicians of the entire United States to handle. It is our responsibility as physicians taking care of patients to decide whether they are or are not totally disabled and whether they are or are not able to engage in remunerative employment.

Two classes of patients will cause difficulty. For the one who is disabled, there is no problem; we can certify him. But there is that group of individuals who think they are disabled or think they should be. These present tough questions. The line is drawn. You have to stand up and be counted and tell such an individual that he is not disabled. That is our responsibility not only to the patient but to the community.

The second group are chiselers. I include those patients who may, through various methods, bring pressure to bear upon the physician in one way or another, through his place of employment, his union, political activity, or what have you. Again it is our responsibility as individual physicians to call these things as they are.

I do not believe that we are warranted in turning over this responsibility to an outside agent. Furthermore, I have heard that the expense involved for the patient in getting all of the work required by the O.A.S.I., that the expense would be very great. However, if we had a private patient with another type of insurance carrier involved we would through the normal channels of consultation and work-up get that information and forward it to the insurance carrier.

I see no reason why the federal government should enjoy preferential treatment along that line. If we set up a bureaucracy, that bureaucracy if it has the authority to make decisions is going to have the authority to make regulations and eventually we will find ourselves having created another Frankenstein that is going to cause us more and more difficulty.

The end result of this program by the federal government is to set up a rehabilitation commission whereby these patients will be taken and attempts made at rehabilitation. This again is the function of the physician taking care of his own private patient and should not be turned over to state or national governments.

We have been placed in the position of being asked to carry out a part of a program established by legislation which we have opposed from the beginning because we did not feel that it was either fair or a workable program. Now we are being asked to contribute to subsidize this program and I do not think it is proper.

Furthermore, Bergen County has already set up a stand-by unit to handle this problem. It would be my suggestion that we do not take action to set up any further units throughout the state this year but that we wait and see what the experience of Bergen County is before diving off the deep end.

I don't think this is the time for us to abrogate our responsibilties and turn them over to some outside agency. Thank you. (Applause)

DR. SCHRETZMANN: Mr. Speaker, I move the adoption of this portion of the report.

(The motion was seconded.)

SPEAKER LANCE: Is there any further discussion? All those in favor will please say "Aye." Opposed? The Noes have it.

(Dr. Schretzmann then read the report through "Essay Contests," which was adopted section by section.)

(Dr. Schretzmann then read "Crippled Children.")

DR. SCHRETZMANN: Mr. Speaker, I move the adoption of this portion of the report.

(The motion was seconded.)

DR. JOSEPH R. JEHL (Passaic): In regard to this resolution I call to the attention of the House that the purpose of this was that we realize that there are things which are not clear in the operation of our Crippled Children's Commission. It has been brought to our attention by doctors in plastic surgery and rehabilitation that there are certain things here which are not in keeping with the activities of New York and Pennsylvania. We didn't want to put those things into the resolution. We didn't think that it was proper to point fingers and say somebody does this and somebody does something else. We requested, as it says in the resolution, that a full investigation and evaluation of this problem by our elected representatives or other persons of integrity seems desirable and for that reason, Mr. Speaker, I would move that this resolution be adopted.

SPEAKER LANCE: The motion is to adopt this portion of the report. Is there any further discussion? All those in favor of adopting this portion of the report will please rise. All those opposed. The "Ayes" have it; the report is adopted.

(Dr. Schretzmann then read the report to its conclusion, which was adopted, section by section, and as a whole, as amended.)

SPEAKER LANCE: Thank you very much, Dr. Schretzmann. You have done a magnificent job. I now call for the report of the Committee on Miscellaneous Business. Dr. John J. Torppey.

(Dr. Torppey read the report of Reference Committee on Miscellaneous Business, (See page 33) which was adopted, section by section, and as a whole.)

SPEAKER LANCE: Thank you very much, Dr. Torppey. (Applause) Next we hear the report of the Reference Committee on Resolutions and Memorials, Dr. Rumkle F. Hegeman, Acting Chairman.

(Dr. Hegeman read the report of Reference Committee on Resolutions and Memorials, (See page 33) which was adopted, section by section, and as a whole.)

SPEAKER LANCE: Thank you very much, Dr. Hegeman. (Applause)

I next call for the report of the Reference Committee on Constitution and By-Laws. Dr. Lorrimer Armstrong.

DR. LORRIMER ARMSTRONG: Mr. Speaker, Mr. President, Members of the House of Delegates: The Reference Committee met on April 28, 1957, with a full Committee present. Business of the Committee was, first to consider Article VI, Board of Trustees — proposed amendment to the Constitution, which had its first reading at the final session of the House of Delegates at the 1956 meeting of The Medical Society of New Jersey; second, revision of the Constitution as presented to the first session of the House of Delegates of the 1957 meeting.

"Article VI—Board of Trustees. The amendment to the Constitution, Article VI, pertaining to the Board of Trustees, was brought up for discussion."

(Dr. Armstrong then read the amendment to Article VI—Board of Trustees.) (Page 195, April JOURNAL)

DR. ARMSTRONG: "It was moved, seconded and carried that the Committee recommend the adoption of this proposed amendment."

Mr. Speaker, I move the adoption of this portion of the report.

DR. H. S. MURPHY (Union County): I second that motion. And now, I make an incidental motion. I move you, Mr. Speaker, that the vote on this be by written ballot.

(This motion was seconded. The Speaker called for a rising vote. The tally showed 135 in favor of, and 105 opposed to a written ballot.)

THE SPEAKER: The "Ayes" have it, and the vote on this will be by written ballot. The motion is now open for discussion.

DR. ERNEST PURCELL (Mercer): Mr. President, Delegates, Friends and fellow practitioners from all over New Jersey: The purpose of the Society is to advance the art and science of medicine, elevate professional standards, safeguard the interests, and promote friendly relations among members of the medical profession, to promote the betterment of public health for the best interests of the people of New Jersey. The Union County resolution, which was almost an identical duplicate of the Mercer County resolution which was passed last year, meets these criteria.

As a boy growing up in a Methodist minister's family, I lived in ten communities, for one to two years each, between Spring Lake and Point Pleasant, down to Sea Isle City and Quinton in the southern part of the state. It was my dad's high respect and friendliness for doctors in those towns and cities that made me interested in medicine. I trust the doctors in rural communities, rural counties as much as those in the cities. I like the doctors who are interested in the care of suffering humanity, whether they come from large or small counties.

Burlington County in the next three years will have an increase in population of over 40,000 people, with 10,000 homes being erected at Levittown. They will require 60 additional doctors to give them adequate medical care at today's standards, and an increase of 250 hospital beds.

Camden County, Gloucester County and Salem County will also have tremendous increases in population. Delaware Valley, U.S.A. in the next five years will have the greatest industrial expansion of anywhere in the United States. From Trenton to the sea there will be an increase in population of over a hundred thousand people in the next five years. They will require proper medical care far beyond what the presently available doctors can handle.

In the United States Senate, Rhode Island, Arizona, Wyoming have the same representation as New York, Pennsylvania, Illinois and Texas. I think the counties are like states. Each county knows what is best for their own county and should have representation to acquaint the State Medical Society of their own problems.

Those living together huddled above an imaginary 38th parallel are not necessarily the ones to judge what is best for so-called grass root counties. (Laughter)

Essex County is opposed to this change, in spite of the fact that they have more representation than any other county. I read from their *Bulletin* of March 1957, Page 141, the action taken by their Council as the only published reason for their opposition. I quote

from Page 141 of that *Bulletin*: "A proposed amendment to the State Society's constitution was read to the Council concerning the enlargement of the Board of Trustees to 21 members, one from each county. The following resolution submitted by Dr. Royal A. Schaaf was then read," and I read a direct quotation from that resolution: "Whereas, under this change the control of the Board of Trustees may pass to a group of smaller counties"—gentlemen, I'd like to read that one sentence again—"Whereas, under this change the control of the Board of Trustees may pass to a group of smaller counties with a comparatively small total membership, with possible serious detriment to the interests and welfare of the larger counties"—and that is the quotation which was passed by the Council of the Essex County Medical Society.

My friends (laughter and applause), as Americans who believe in democratic representation and fair play, I ask you to again support the Union County resolution for the second official time. (Applause)

DR. DONNELLY (Hudson): I do not rise to defend Essex County, because I have differed with them more often than I have agreed with them. But I think that some of the things which Dr. Purcell says were very true, one of which was that doctors in all parts of the state should be adequately represented and equally represented and therefore, gentlemen, I think that the doctor or a group of doctors in Essex County should have equal representation, not equal representation but should have as fair representation as the doctors from Salem or Gloucester County.

If this amendment goes through, a doctor in Salem County will have thirty times as much representation on the Board of Trustees as a doctor in Essex County because one delegate from Essex represents 1500 men.

When this constitution was drawn up, the state was divided into Judicial Districts so that each District would have two trustees. In that way each part of the state would have some representation on the Board.

If you will look at the Board of Trustees and the elected delegates for next year and if you will count them over, as I have, you will find that the smaller counties, representing a very small proportion of the total number of doctors, will not be without representation. They will have some nine out of the twenty-two members of the Board of Trustees and the elected delegates. I don't think that's unfair.

Essex County for some time has had too many representatives on the Board of Trustees. I am one of the people who have come up and said that. They now have three for 1500 members. That is not too much out of the question. My own Hudson County has one; we have 700 votes. Bergen has one. So it's not a case of the larger counties running this whole thing.

The agency which largely influences our elections is the Nominating Committee where each county, regardless of its size, has one vote. It is a very important vote because you people who, like myself, have been coming to these conventions for years, and think of all the hundreds and hundreds of people who have been nominated, can probably remember only a half a dozen times when the House of Delegates overruled the Nominating Committee. So that the smaller counties do have adequate representation.

And don't let us think for a minute that this resolution which is before you today is brought up by the smaller counties. If there was any one slogan for this convention, I think it should be: "In Union there is disagreement." (Laughter and applause) Up to now they have seldom agreed and frequently dissented, which is their right, but I think there has been some rightful, some wrongful dissatisfaction with the Board of Trustees. You have the process, gentlemen, of changing that with your House of Delegates. You don't have to change the whole constitution which has been working perfectly well for a good many years, just to change a few people on the Board of Trustees. You can do that in the House of Delegates any time you have the votes. If you have the votes today, you can change them today. And I think that it is most important that all counties be given something like equal representation. Hudson and Essex and Bergen and the large counties will never be given equal representations on the Board of Trustees for the number of doctors they have in their counties. But they should be given something like equal representation. A county with 42 votes, 42 doctors in it, a county society that can hold a meeting in a telephone booth and with eight doctors present, should not have the same representation on the Board of Trustees as the larger counties. I think the time has come, and I think I have to say this, that everybody should have an equal vote.

One other point. There is one part of the State Society which has county representation —the Welfare Committee—and it is on the Welfare Committee where all these counties are represented. The average attendance at the Welfare Committee is 40 per cent against the Board of Trustees where it is over 90 per cent. It's all right to say you are on the Board of Trustees, but they still have to get there on their seven Sundays throughout the

year, and I think that's most important, and I don't think just because somebody is in some geographical locality that he automatically becomes a member of the Board of Trustees of the State Society. Thank you.
(Applause)

DR. WINTON H. JOHNSON (Bergen): We have a very definite democratic principle here. The House of Delegates last year saw fit to pass this on its first vote. There is no question in the democratic way of thinking that the doctors in a large county should have equal representation. We in our county saw fit to vote for the Union County resolution. It was on the basis that this was only the first step in the sense that we would get representation from each county. We were all in agreement that the larger counties should have more representation, but I see no reason why another resolution could not be put into effect whereby the larger counties could have a proportionate representation according to one trustee for every two or three hundred physicians, or whatever system could be worked out.

At least we have now cleared through one reading the resolution before us. If we adopt this, we have made a progressive step. We are getting representation from all the counties.

Dr. Donnelly has been rather emotional. I have yet to see the telephone booth in which eight doctors could meet and have a meeting. (Laughter) But sometimes those are the things that tend to try to sway us. And as far as I know, the Legislative Committee of our Society has had as admirable an attendance and I think the doctors on the committee show their interest. I am sure that a trustee from a smaller county will make just as much effort to come here to a trustees' meeting as a doctor from a larger county where perhaps he has a much bigger practice to take care of. And I think the smaller counties need representation and I fully believe that if we make this first step a possibility, we can certainly make the next step, which is to give the larger counties their proper representation, and I definitely feel that this is the democratic way of doing it and I think that that is what we ought to do. Thank you. (Applause)

DR. HENRY BRODKIN (Essex): Gentlemen, I am a member of the Essex County Medical Society. I hold no office, probably never will. I'm just a plain member and I rise to express our position on this amendment and refute the arguments presented that this is a democratic system.

Now, who will these trustees represent if they represent each county from which they come? Will they represent the traders, the farmers, the merchants or will they represent the physicians of their county? If they are to represent the physicians of their counties, is it fair for one man to represent 37 doctors with equal voice and power as a man who will now represent 1600 physicians?

Members of the Board of Trustees do not represent any section or county. Their purpose is to represent our profession during the interim when this House of Delegates is not in session. They are an executive body, not a legislative one.

Now, as long as the analogy was raised to our system of government, let me pause for one moment to appraise this political representation that we have. New York, 15 million; California, 12; Pennsylvania, 11; Illinois, 9; Ohio 8, together represent 55 million people or 33 per cent of the population with 10 senators. Nevada, Delaware, Vermont, New Hampshire, Montana, each 160,000, 300,000, 400,000, 600,000 — two million people, or 1.2 per cent of our entire population. Ten Senators. Does that mean equal representation, in your minds?

When the Articles of Confederation were found inadequate and the Constitutional Convention was called there was that same fear. Rhode Island absolutely refused to attend and for months they haggled. The Virginia Plan was proposed, which didn't even allow for Congress, just an executive and judiciary; each state was to exercise its own power. Then came the New Jersey Plan, and finally in order to compromise — and it wasn't that it was thought to be the best plan, but it was a compromise to protect the small states and areas that two Senators were permitted from each state. For over a hundred years the people never elected the Senate. The Senators were elected by their legislators, until, if my memory serves me right, the year 1913.

Now, let's apply this to counties. Essex with a million people and 1600 doctors; Hudson, 650 to 543 doctors; Bergen, 557 doctors; Union, 550; Passaic, 547— 4,000 doctors, almost 50 per cent of our physicians. As opposed to Sussex, Cape May, Hunterdon, Salem, Warren, 34,000, 37, 42, 49 — 272,000 people, 4 per cent of the population.

Dr. Purcell speaks to us of the future, of what is going to happen in these counties. When that arises, we certainly will meet with those conditions. They represent a mere 3 per cent of the physicians of our state.

Now, if we have this type of representation, is it democracy? Isn't it stretching the good word that some of these dictators use to cover up some of the things they like to perform? But aside from that, I have here the Nomin-

ating Committee report of the officers of our Society. I see Warren, Cumberland, Cape May —all counties represented. It's really a fine reflection on the workings of our Society. It is a democratic organization and now you want to instill a factionalism, a sectionalism, countyism. It's the very thing that destroyed Europe, so that today they are thinking of a united Europe.

I appeal to you gentlemen. Let's not think of this executive body, which is an efficient body because it is a small group, in terms of county representation. Let us think in terms of getting the best men we have.

Now, if you were to say let's increase the number, I would remain silent. But when you say put it on a county basis and let 37 doctors send a member to the Board of Trustees, I think it will prove inefficient. Thank you very much. (Applause)

DR. ARMSTRONG: Mr. Speaker, I have traveled this world a fair amount. This country, I think, still is the best one to live in. I like the State of New Jersey. In the Senate of the State of New Jersey Cape May has one Senator; Essex has one Senator. I haven't read in the papers where Essex County is all hot and bothered about this lack of democracy. It's always amazing to me that they don't realize that the best brake we have on improper legislation in these United States is the Senate. You all realize some cockeyed legislation comes out of the House of Representatives not infrequently. Were it not for that good body, I don't know what would happen.

I want it clearly understood right here that Union County is not criticizing any Trustee of this Board. I have been a member of this Society since 1928. I think it probably has more than doubled in its membership. I don't think the Board of Trustees has doubled, not at all. We are not criticizing anybody; we don't think anybody is crooked. But we feel that having representation from each county of this state, in view of the fact that we are now approaching 6,000 practicing doctors in this state, about 55 or 5600 belong to this Society, we cannot feel any smaller counties will at any time gang up on anybody. After all, we are doctors. I don't think you see in this Society any time anybody trying to gang up. We may differ, certainly; that's a good prerogative, gentlemen.

Now, Union County is not trying to pull the wool over anybody's eyes. We think it's a good deal and we ask your support. (Applause)

DR. SPENCER SNEDECOR (Bergen): Mr. Speaker I move the previous question.

DR. MURPHY: I second that motion.

SPEAKER LANCE: This motion is not debatable. Since it requires a two-thirds vote, I will ask you to rise. This is a motion to terminate debate. All in favor of this, please rise. We count 193 for and 57 against previous question. That means that 250 votes were cast and two-thirds of 250 is 166. Since there were 193 "Aye" votes, Dr. Snedecor's motion passes and debate is terminated.

We will therefore begin now with the written tally of the main motion—the amendment of this part of the Constitution.

DR. BRODKIN: Mr. Speaker, will you please state the amendment so that the Delegates would know what a yes would mean and what a no would mean?

SPEAKER LANCE: A "Yes" vote in this instance will mean that Article VI is approved and becomes operative as a part of the Constitution. A "No" vote will mean that it is defeated and that it cannot be operative. If there is a "No" vote, the Board of Trustees will remain as it is. In other words, a "Yes" vote will increase your Board to 21; a "No" vote will keep that Board of Trustees where it is.

The balloting will commence. The Secretary will call the names of the Delegates by counties and you will come down this aisle, deposit your ballot, and go back this way.

SECRETARY GREIFINGER: I'm calling the Fellows first. In addition to the Fellows at this time I'm also calling the Officers and Trustees, so that now the Fellows, Officers and Trustees are voting.

(The balloting then took place.)

SPEAKER LANCE: Now, gentlemen, that completes the balloting. I wish to make this announcement. The Chairman of the Committee on Credentials informed the Chair that there were registered as present this morning 318 Delegates. That means then that in order for this motion to pass, 212 votes will be required. I just wish to make that announcement prior to the counting of the ballots.

I will ask the tellers if they will retire to one of the rooms outside and count the ballots while we continue the business of the session.

I'm making that announcement. The fact that not everybody voted has nothing whatever to do with it. Our Constitution says that it requires a two-thirds vote of those present, and 318 men were registered as present; therefore it will require 212 votes to pass.

Dr. Armstrong will now continue with his report.

(Dr. Armstrong then read the balance of the report (See page 34) through "Article XI—Seal," which was adopted, article by article and section by section.)

Dr. Armstrong then read "Article XII—Amendments to the Constitution."

Dr. Armstrong: Mr. Speaker, I move the adoption of this portion of the report.

(The motion was seconded.)

Dr. Graham C. Newbury (Union): I'd like to move an amendment to Paragraph 1 which states: "Submission of the proposed amendment in writing, through the Secretary of this Society, to the Standing Committee"—I would like to add "and to each component medical society." The reason is that if a proposed amendment is given to you here at the meeting, you have only a very short time in which to study it. The only time you can make changes and amendments to the proposed amendment is at the first reading. Although it's published thirty days before the final reading, you have to take it or leave it the way it is at that point and no revision is possible. So that since the proposal has to be sent to the Standing Committee on Revision of Constitution and By-Laws, it would be just as easy to send it to each component medical society so that each society could study it before coming down here.

And I'd like to propose this amendment: I move that "to the Standing Committee on Revision of Constitution and By-Laws and to each component medical society" be added to this paragraph.

(The motion was seconded.)

Speaker Lance: Is this new material that is being injected into the study of the Constitution? Dr. Newbury, I'm asking you a question. Was this proposal that you have just read considered by the Reference Committee yesterday?

Dr. Newbury: No, it was not. If you will look at your By-Law you will find on reports of reference committees that anyone has the privilege to make amendments from the floor. That's at the first reading. You can't make amendments to any other reading.

Speaker Lance: That's perfectly all right.

Now, gentlemen, this also requires a two-thirds vote. You have heard the reading of the amendment. Is there any discussion? Will those in favor of this amendment please rise and be counted? Thank you. Please be seated.

All those opposed please rise.

That one is carried. That is added to the first reading.

Dr. Newbury: I have another amendment to propose in Paragraph 8: "Acceptance by a majority vote of the members of the House of Delegates present" *and voting* "at the final session." That is: Paragraph 8, Page 9 under Amendments to the Constitution. I want to add: "Members of the House of Delegates present" *and voting* "at the final session," both to this Paragraph 8 and over on the next page Paragraph 10: "Adoption by a two-thirds vote of the members of the House of Delegates present" *and voting* "at the final session."

I move that these two paragraphs be amended to read that.

(The motion was seconded.)

Dr. Albright: I think that the wording does need clarification. It was our intent to put the clarification in the By-Laws which will become effective at the same time the Constitution becomes effective. Now, it doesn't make too much difference how you do this. Our original purpose was to clarify this two-thirds of the members present. What constituted members present? Did it constitute those present when the session opened or those present when the question was heard? That was to be clarified in the By-Laws. So far as our Committee, we'll accept the verdict of the House of Delegates, of course. You can leave it as it is or accept the amendment.

Speaker Lance: Is there any further discussion relative to the amendment offered by Dr. Newbury to these last items? All those in favor say "Aye." All those opposed? So ordered.

Dr. Armstrong: My motion is to approve this portion of the report.

(The motion was seconded.)

Speaker Lance: It has been moved that this portion of the report be approved. Any discussion? All those in favor say "Aye." Opposed? So ordered.

Dr. Armstrong: I want to take this opportunity to thank my Committee—Dr. Nicholas E. Marchione, Dr. Erwin P. Sacks-Wilner, Dr. Joseph R. Jehl, Dr. Harry W. Fullerton, and members of Dr. Albright's committee at the Reference Committee meeting.

Mr. Speaker, I want to move that the report as a whole, as amended, be accepted.

(The motion was seconded.)

Speaker Lance: Is there any discussion? All those in favor of this motion will say "Aye." Opposed? It is so ordered.

Thank you very much, Dr. Armstrong. (Applause) We realize what a tremendous job this Committee has done and we are very appreciative of the time and effort they put in.

You will recall that when this balloting was ended I made the statement that 318 Delegates had been registered as being present and that therefore it would require 212 votes in order to carry this amendment. We find that instead of 318 voting, 275 votes were cast. Now two-thirds of 275 is 184. At the request and suggestion of the Parliamentarian I explain that 184 or two-thirds of those present and voting would be required to carry the amendment. The Secretary is going to post the count for your information. 142 "Yes"; 133 "No," which indicates that the motion is lost.

Two small items of new business have come up. At this session, unanimous consent is required. Ladies and Gentlemen of the House may I have that unanimous consent? Does anyone object? Hearing none, I call on Dr. Decker for the first item.

(Several Delegates said "Yes.")

DR. DECKER: This is a proposed amendment to the Constitution.

This proposed amendment is to "Section 2 —Groups (a) Fellows. The Fellows are the Ex-Presidents of the society."

The proposal is to add the following paragraph: "Any member of this society, not already a Fellow, who is elected President of the American Medical Association, shall at the completion of his term, become a Fellow of the society."

This has been presented to Dr. Albright's Committee on Revision of the Constitution and By-Laws and he has attached an affidavit to this. "To Whom it May Concern: The above proposed amendment was considered and studied by the Committee on Revision of the Constitution and By-Laws on Sunday, April 28, 1957. Initial consideration was by consultation between the Chairman and each member. In this fashion consultation was had with Drs. Gannon, Hollingsworth, Kustrup and Kump. Of the Committee members so contacted, a favorable recommendation for the proposed amendment was obtained. Later in the day, April 28, 1957, at 3:30 p.m., a meeting was held which was attended by Drs. Gannon, Hollingsworth and Albright. Again a favorable and approving recommendation was passed by the Committee.

"To bring the proposed amendment into line with the proposed revised version of the Constitution and By-Laws, the Committee suggested that the proposed amendment be stated as follows: 'The Fellows are the *Past*-Presidents of the Society. Any member of this Society, not already a Fellow, who is elected President of the American Medical Association, shall, at the completion of his term, become a Fellow of the Society.' "

Signed by Dr. Louis F. Albright, Chairman of the Committee on Revision of Constitution and By-Laws.

Mr. President, may I submit this as the first reading of the proposed amendment?

SPEAKER LANCE: This has had the approval of the Committee on Revision of Constitution and By-Laws and it will stand as an amendment to Article IV, Section 2, provided it is voted upon. Did you move that?

DR. DECKER: I move that it be accepted as the first reading.

(The motion was seconded.)

DR. ARMSTRONG: This is a small point, but just to keep the record straight we will have to number or letter the sections—Section A would be the present section and Section B the new one. At present the Constitution says the Fellows are the Past-Presidents. You've got to make a section out of that and to account for this if you are going to let two groups of people be Fellows. See what I mean?

DR. DECKER: This is Dr. Albright's recommendation.

DR. ARMSTRONG: I want to be sure that was understood there. Article IV, Section 2 says: "The Fellows are the Past-Presidents of the Society." You've got to make that: The Fellows are the Past-Presidents of the Society, Paragraph A; and it should be changed to read: Fellows may be the Past-Presidents of the Society.

DR. ALBRIGHT: I think it can be all kept in one sentence and one section. Of course, it's a small thing to argue about.

SPEAKER LANCE: This is the opinion of the Chairman of the Committee on Revision of Constitution and By-Laws. Let's put it through that way if you are in favor of this motion. All those in favor please rise. Thank you. All opposed? Thank you very much.

(Carried unanimously)

DR. RUDOLPH G. MATFLERD (Middlesex): This resolution that was not put through committee deals with the inspection of hospital records in cases involving litigation. It includes compensation cases, or for that matter any cases where there are claims involved.

SPEAKER LANCE: This is new business and therefore unanimous consent is required. Any

objections? Hearing none, I rule that you may read the resolution.

Dr. Matflerd: "Whereas, Chapter 286 of the Laws of 1945, R. S. 2A:82-41 *et seq.*, allows for the examination of hospital records of patients against whom or by or for whom a claim is asserted for personal injuries or death resulting either under the Workmen's Compensation Act of the State of New Jersey, Chapter 15 of Title 34 of the Revised Statutes, or at law; and

"Whereas, experience under this statute has proved that hospital records have been indiscriminately examined by unauthorized persons; and

"Whereas, it is imperative for the protection of the patients that this abuse be stopped; it is, therefore,

"Resolved, that Chapter 286 of the Laws of 1945, R. S. 2A:82-41 *et seq.*, be amended to allow for examination of hospital records only upon the consent in writing of either the patient against whom or by or for whom a claim is asserted for personal injuries or death resulting either under the Workmen's Compensation Act of the State of New Jersey, Chapter 15 of Title 34 of the Revised Statutes, or at law, or by his treating physician or in the event of the death of the said patient, then by his legal representative, or in lieu thereof by an appropriate order of a court of proper jurisdiction."

Speaker Lance: Thank you, Doctor. That resolution will be referred to the Legislative Committee for consideration.

President Fritts: Now, gentlemen, I wish to present to you Jesse McCall, whom you have elected as the Second Vice-President of your Society. Jesse, will you stand up and take a bow? (Applause)

And now I'll call Dr. David Allman to the stand. He will introduce to you and talk to you about our new President, Dr. Albert Kump. (Applause)

Dr. Allman: Mr. President, Officers of The Medical Society of New Jersey, Delegates and Friends: I know some of you are hungry and some of you are thirsty, and while I could stand here for hours and extoll the virtues of our newly elected President I'm going to make this as short as I can, consistent with the honors that are due him.

I have a long biography here of my good friend, Albert B. Kump, and I would like to read a lot of it to you, but I know you are impatient. I might say right here that I feel highly honored in being asked to do this because I feel that in presenting your newly elected President I'm presenting a man of great virtue, a man who will lead us during the next year through the trials and tribulations of the State Society with high honor and great credit. He is a young man.

For those of you who do not know, his mother was a physician. His mother was also the President, at one time, of the Cumberland County Medical Society, at a time when some of you did not think too much of women doctors. He is a real Jersey boy. He got all his education in New Jersey, in the way of preliminary education; then went to Johns Hopkins, finally the University of Maryland in Baltimore, and interned at the Cooper Hospital. Albert has been in general practice in Bridgeton since 1939 and has had a remarkable career.

I could go on for hours and extoll his virtues. He is a great personal friend of mine. He is a great friend of organized medicine and he is going to make a great President for this Society.

I had a long speech prepared, but the shortness of time has changed my mind, but it was a letter from a very fine person that made me decide to use her letter as my introduction of our good friend, Al Kump, to you. You heard this lady this morning. She was the first speaker on the platform, and she wrote to me just recently. She is Secretary of the Cumberland County Medical Society, and in that capacity sent me the biography of Albert that I asked for. And she wrote to me:

"Dear Dr. Allman: The enclosed biographic material seems so inadequate and coldly factual I would like to write you a few words.

"We will ask you to bring to life the warmth and strength that is Albert's. Because of the sheer force of his personality, his ability, his willingness to help the other physicians of the community, we all came to depend upon him and rely upon him heavily. Whenever I—and I am just a symbol—was 'over my head' I called for Albert and Albert had one stock reply: 'I'll be right over.' And this he did for any and all, day and night, over a period of a great many years. He always placed community affairs, his patients, the hospital and his colleagues far above his own personal affairs. Everyone in Cumberland County respects him and many of us love him.

"His father is still living and is one of the finest men I have ever known. His mother was a beloved Bridgeton physician, a Past-President of the Cumberland County Medical Society, and that, of course, when women physicians were not accepted without reservations as they are now."

And I continue to quote from Mary Bacon's letter: "Cumberland County Medical Society could not have as President of The Medical Society of New Jersey a more worthy representative."

And all I can add to that is that I feel we in New Jersey could have no more repre-

sentative man for the President of our State Society than Albert B. Kump. And as a personal friend of his I want to congratulate him in behalf of the American Medical Association; I want to extend him our best wishes, and I'm sure that you will all join me in the feeling that we have for this coming year another great leader—Albert Kump.

(The Delegates arose and applauded.)

Dr. Albert B. Kump: Mr. President, Mr. Speaker, Members of the House of Delegates: I wish to thank Dr. Allman in his busy schedule for taking the time to introduce me.

I have no speech to make at this time except to assure you that I will do everything I can for the good of The Medical Society of New Jersey.

Probably the most beneficial thing I can do at this time is now adjourn this 191st meeting of The Medical Society of New Jersey. (Applause)

(At 2:10 p.m. the House adjourned *sine die.*)

REFERENCE COMMITTEE REPORTS

REFERENCE COMMITTEE "A"

Mary Bacon, M.D., Chairman

Reference Committee "A" met on April 28, 1957, at 11:00 a.m. Members present were: Harry N. Comando, M.D., Volmar A. Mereschak, M.D., Noah Meyerson, M.D., Jacob M. Schildkraut, M.D., and Mary Bacon, M.D., Chairman.

President (See page 177 of April JOURNAL)

The report of the President of The Medical Society of New Jersey was carefully studied. The committee asks recognition of the accomplishments of President Lewis C. Fritts and his administration. It was noted that no sphere of proper concern has been unregarded. A recognized thread of policy runs through the entire presidential report, summarized in the last paragraph of the reporting President: "We need men and women who in their daily practice will deal with their patients not only efficiently, but so intelligently and compassionately that they will make each patient a stalwart admirer of the entire medical profession. We need men and women of such character and worth that each will be an influence for better public relations with all their patients. In short, we need men and women who love Medicine and their fellowmen, and who serve what they love unselfishly."

Secretary (See page 193 of April JOURNAL)

The report of the Secretary, Dr. Marcus H. Greifinger, was considered in detail. The Secretary is commended on the enormous amount of detail successfully carried on with the help of a most efficient clerical staff. It is noted that the 3rd edition of the Membership Directory will be published in the fall of 1957. As of recent date, there were 6,587 listings. We commend the Secretary on his attendance at all relevant meetings, obviously requiring much time, effort and interest.

Board of Trustees (See page 194 of April JOURNAL)

The report of the Board of Trustees was next reviewed. Dr. C. Byron Blaisdell, chairman, reported much heavier demands upon the time of the Trustees—eight meetings in all, of which there were more than 210 pages of minutes. We wish to record the gratitude of The Medical Society of New Jersey to the Board of Trustees, and its chairman, Dr. Blaisdell.

The report shows loyal and diligent service in the interest of the Society. The Trustees report that Robert A. Backes has served as counsel for The Medical Society of New Jersey for the current year, and is parliamentarian at the annual meeting.

In anticipation of the bicentennial in 1966, of the founding of The Medical Society of New Jersey, the Trustees created the post of historian-archivist, and appointed Dr. Fred B. Rogers. Dr. Rogers will prepare the historical materials to be utilized in 1966.

The Board by the following statement, set current policy in the matter of euthanasia — "The practice of euthanasia has been and continues to be in conflict with accepted principles of morality and sound medical practice."

Judicial Council (page 177, April JOURNAL)

The report of the Judicial Council, Dr. Daniel F. Featherston, chairman, was next reviewed. This Council has served as appellate tribunal considering matters originally dealt with by the county judicial committees. It has also had the responsibility of supervising, directing, and keeping records of all complaints that were dealt with by county judicial committees as matters of original jurisdiction. To accomplish this, the Council, through the cooperation of county judicial committees, receives reports of all cases accepted for adjudication by county judicial committees, and of the disposition made of them.

Reference Committee "A" recognizes the time-consuming and patience-exhausting efforts of the Judicial Council and approves this report.

Executive Officer (page 181, April JOURNAL)

Next on Reference Committee "A" agenda was the report of the Executive Officer, Mr. Richard I. Nevin. This calls to our attention the multitudinous facets of modern organized medicine, and with amazement we reviewed the activities of the Board of Trustees and the various committees and executives; and in coordinating all this, of the Executive Officer, Mr. Nevin.

The report called to attention official and social engagements of the Executive Officer, as the Society's representative, to the extent of more than 118 meetings, and 23 speaking engagements. The report shows progress in the Society's organization and in its efficiency in functional operation.

The Executive Officer states: "These are days to try the mettle of Medicine as a profession, and of physicians as individuals. We must stand and work together, within the framework of our Society's structure, to preserve the best that we have —for our fellow citizens and ourselves—and to resist the deleterious and unwholesome changes that our adversaries would thrust upon us."

Medical-Legal Testimony (page 38, these Transactions)

Next was considered a supplemental report of the Board of Trustees which states: "The 1956 House of Delegates adopted a resolution calling for a committee to be set up to study the problem of malpractice." A report was received by the Board of Trustees from the chairman of the Special Committee on Medical-Legal Testimony, Dr. Marcus H. Greifinger: "This committee has explored all seemingly feasible approaches to solution of the problem and can arrive at no workable solution. The

joint committee therefore agreed to recommend that the proposal be abandoned."

The recommendation of the joint committee was approved by the Board of Trustees.

Referring to the study of medical testimony in compensation courts,* on a statewide basis, the special committee requested, and the Board of Trustees approved, that the "study of medical testimony in compensation courts on a statewide basis" be held in abeyance and referred to next year's committee.

(*Page 38, these Transactions)

Action: Page 11

REFERENCE COMMITTEE "B"

William F. Costello, M.D., Chairman

Reference Committee "B" met at 11:00 a.m., April 28, 1957, all members being present.

Treasurer (page 35, these Transactions)

This report was considered in detail. Many questions were asked as to the policies followed, all of which were explained by Dr. Jesse McCall, our Treasurer. It is the unanimous opinion of your committee that this facet of our organization is capably handled.

As a result of discussion with the Treasurer and Mrs. Madden, Administrative Secretary, your committee would make two suggestions:

1. To simplify and expedite the work at the headquarters office, we exhort the county treasurers of each county society to make fractional remissions of dues and not wait until a few days before the deadline. This will simplify the work of the county treasurer and greatly assist the headquarters staff.

2. Your reference committee suggests that the Board of Trustees and the Treasurer explore the advisability of short term investments, if and when the checking account justifies that procedure.

Finance and Budget (page 43, these Transactions)

A careful survey of the receipts and disbursements was made, and many questions were satisfactorily answered by the Chairman, Dr. Allman. During the past year a capital expenditure of $15,000 was made on the headquarters building. Our donation of $25,000 to the AMEF made a deficit of $15,000 in our capital fund, due to a difference in the fiscal and calendar year. The Membership Directory, published every two years, is charged against this year's budget. These three items are all reflected in this budget.

The Reference Committee recommends:

1. The cost of the Directory, published every two years, be prorated every year.
2. That if a contribution is authorized to AMEF, that it not exceed $10,000 this year.

The Reference Committee approves the following recommendations of the Finance and Budget Committee:

1. That the proposed budget for 1957-58, in the amount of $207,975.00, be approved.
2. That the 1958 assessment be $40.00 per member.

Student Loan Fund (page 175, April JOURNAL)

The Board of Trustees recommends that the 1957 House of Delegates approve using the funds in the Permanent Capital Fund for the purposes of the Medical Student Loan Fund of The Medical Society of New Jersey.

Publication Committee (page 183, April JOURNAL)

A review of this report was indeed heartening. The Publication Committee processed this year's work with no deficit and asked for no financial aid from the Society. Your Reference Committee is unanimous in expressing its satisfaction with the continued progressive improvement in our publication.

Particularly pleasing is the fact that the British Bibliography of Medical History thought worthy of including in its publication, an article recently appearing in our JOURNAL entitled "His Name was Mudd." We feel that our Society owes a vote of appreciation to our JOURNAL staff.

Medical Service Administration (page 176, April JOURNAL)

The report of the Board of Trustees indicating a subsidy of $5,000 to Medical Service Administration was noted. The public relations value of this organization was again emphasized, and your Reference Committee approved this action of the Board of Trustees.

The Reference Committee wishes to express its appreciation to Dr. Allman, Dr. McCall, and Mrs. Madden for their attendance at the meeting and for their assistance.

Action: Pages 11 and 12

REFERENCE COMMITTEE "C"

F. Clyde Bowers, M.D., Chairman

Reference Committee "C" met on April 28, 1957, with Dr. Spurgeon, Dr. Kustrup, Dr. Olpp, and Dr. Bowers present.

Your committee considered 17 items referred to it by the House of Delegates. There were some 50 to 75 people in attendance, and a thorough and open discussion was held in regard to each item presented.

The following actions were taken:

Medical-Surgical Plan of New Jersey (page 200, April JOURNAL)

The reference committee approved this report and commended the work of the Board of Trustees

of Medical-Surgical Plan, but suggests that Medical-Surgical Plan include in its annual report a publication of the percentage of payments made to the various specialties.

Medical-Surgical Plan Contract Changes (from the Board of Trustees) (page 176 April Journal)

This item was approved as published. Your reference committee would like to remind the House of Delegates that it cannot issue directives to Medical-Surgical Plan, but can only make recommendations.

Medical Fees in Medical-Surgical Plan (from the Board of Trustees) (page 177, April Journal)

This item was approved as published.

Nominations to Board of Trustees of Medical-Surgical Plan (from the Board of Trustees) page 39, these Transactions)

The nominations as presented were approved.

Medical-Surgical Plan Physician Lists (from Bergen County) (page 198, April Journal)

The reference committee approved this resolution in principle, if feasible. Your reference committee suggests that the wording in the last paragraph be changed as follows:

That the word "directed" be changed to "requested"—the last paragraph to now read:

Resolved, That the Board of Trustees of Medical-Surgical Plan be requested to revise the physician lists immediately.

Indemnity Basis for Medical-Surgical Plan (from Union County) (page 56, these Transactions)

This resolution was disapproved by your committee for the following reasons:

A. Beyond the limits of a $5,000 single income and $7,500 combined income, the Medical-Surgical Plan becomes an indemnity plan.
B. For the non-participating physician, it is in essence an indemnity plan.
C. In this inflationary period, the $5,000 to $7,500 income group is a proper group to have in a service plan.
D. And further, any effort to change our present Medical-Surgical Plan from a service type of plan to an indemnity type of plan would necessitate complete dissolution of our present Medical-Surgical Plan.

Medical-Surgical Plan Contract Inequities (from Middlesex County) (page 56, these Transactions)

With reference to this particular resolution, the reference committee recognizes that there are certain inequities. We approve it in principle, but we feel that it will require further study. Therefore, we ask that it be referred to the Board of Trustees of The Medical Society of New Jersey and of Medical-Surgical Plan.

Medical Service Administration (page 199, April Journal)

The reference committee approved this report as submitted.

Medical Service Administration Supplemental Report on Medicare Program Claims (page 56, these Transactions)

The reference committee approved this report as submitted.

Nominations to Board of Governors, Medical Service Administration (page 39, these Transactions)

The nominations, as presented, were approved.

Medicare (from the Board of Trustees) (page 176, April Journal)

The reference committee approved this report as submitted.

Medicare Program (from Radiologists and Pathologists) (page 39, these Transactions)

The reference committee approved this resolution as submitted.

Hospital Service Plan Medical Services (from Mercer County) (page 197, April Journal)

The reference committee approved this resolution in principle. However, since the Board of Trustees of The Medical Society of New Jersey has proposed certain principles in approach to the specialty services which were considered by Reference Committee "E," and which we hope will be adopted by the House of Delegates, your committee feels that this matter should be referred to the general meeting or meetings that will be convened by the Board of Trustees, which will include representatives from the specialty societies concerned, the Hospital Association, Medical-Surgical Plan, and Hospital Service Plan.

Hospital Service Plan Medical Services (resolutions from Monmouth, Burlington) (page 197, April Journal), and identical resolutions from Bergen and Essex Counties.

These resolutions were approved in principle, and the same comments obtain as stated for the Mercer County resolution reported on above.

Blue Cross Admissions (Supplemental Report of Board of Trustees) (page 42, these Transactions)

The committee concurred in the recommendation of the Board of Trustees that the information contained in the letter issued by the Insurance Committee of the Monmouth Memorial Hospital to its staff members be transmitted to the membership of The Medical Society of New Jersey.

Policies of Medical-Surgical Plan (Resolution from Union County) (page 7, these Transactions)

The reference committee approves this resolution in principle, but recognizing that the appointment of members from the Board of Trustees of Medical-Surgical Plan might constitute an act of impropriety, it is suggested that they not be included as voting members of this committee.

Action: Pages 12 to 17

REFERENCE COMMITTEE "D"

George E. Barbour, M.D., Chairman

Reference Committee "D" has for its consideration the reports on Physicians Placement Service; Widows and Orphans of Medical Men; Medical Education; Emergency Medical Service, Civil Defense; Professional Liability Insurance (Resolution from Hudson County); and False Complaints (from the Board of Trustees).

Physicians Placement Service (page 194, April JOURNAL)

The reference committee unanimously approved the report of the Physicians Placement Service. The reference committee commends the Physicians Placement Service for its work this past year.

Widows and Orphans of Medical Men (page 194, April JOURNAL)

This report was accepted by the reference committee.

Medical Education (page 45, these Transactions)

Because of the unfortunate and untimely death of Dr. Gerald I. Cetrulo, Chairman of the Medical Education Committee, the report submitted was an abstract of the minutes of a committee meeting. Your reference committee recognizes the need and desirability of determining the wishes of our members concerning the extension of post-graduate courses throughout the state. However, it does not feel that the limitation on the supervision of such courses to one institution is in the best interest of The Medical Society of New Jersey. Since the recommendation of such limitation seems to be the only recommendation contained in this report, the committee recommends the rejection of the report as compiled.

Emergency Medical Service, Civil Defense (page 48, these Transactions)

The reference committee unanimously approved the report of the Special Committee on Emergency Medical Service, Civil Defense, and commends the committee for the time and effort given this subject.

Medical Defense and Insurance (page 44, these Transactions)

The reference committee unanimously approved the report of the Medical Defense and Insurance Committee, which included the recommendations that Faulhaber and Heard and E. & W. Blanksteen be continued as the official brokers for the Society in their respective fields. The reference committee commends the Medical Defense and Insurance Committee for the time and effort they have devoted to the interests of our members.

Professional Liability Insurance (Resolution from Hudson County Society, to wit:) (page 57, these Transactions)

Resolved, that The Medical Society of New Jer-Jersey be requested to investigate the plight of those members who—having been involved in litigation with reference to professional liability—thereafter find it impossible to obtain proper coverage except at excessively high rates.

The reference committee approved the purpose and intent of the resolution submitted by the Hudson County Medical Society. The committee recommends that the membership be informed that we have in the State Society a committee on Medical Defense and Insurance which handles these problems for all physician members of the Society regardless of the insurance carrier when requested by the physician concerned.

False Complaints (from the Board of Trustees) (page 41, these Transactions)

The reference committee approved the Supplemental Report of the Board of Trustees on False Complaints.

Action: Pages 17 and 18

REFERENCE COMMITTEE "E"

Rudolph C. Schretzmann, M.D., Chairman

Reference Committee "E" met on April 28, 1957, with the following members present: E. Vernon Davis, Raymond J. Germain, Herschel S. Murphy, Baxter H. Timberlake, and Rudolph C. Schretzmann.

The Committee considered 15 committee reports, three referrals from the Board of Trustees, and 10 resolutions in their deliberations.

The Reference Committee approved the following committee reports as presented — these reports contained no recommendations:

Welfare (page 185, April JOURNAL)
Maternal and Infant Welfare (page 186, April JOURNAL)
Cancer Control (page 186, April JOURNAL)
Legislation (page 46, these Transactions)
Medical Practice (page 188, April JOURNAL)
Public Health (page 189, April JOURNAL)
Public Relations (page 187, April JOURNAL)

Conservation of Hearing and Speech (page 190, April JOURNAL)

Conservation of Vision (page 191, April JOURNAL)

Mental Health, page 192, April JOURNAL)

Rehabilitation (page 193, April JOURNAL)

Routine Health Examination (page 47, these Transactions)

School Health (page 47, these Transactions)

The Reference Committee wishes to go on record to thank all those who were responsible for the tireless effort and toil that went into the consideration and solution of all these important and controversial problems. The unsung toilers in the vineyard have only this opportunity for recognition and the Reference Committee takes this opportunity of recognizing their contributions to organized medicine.

Workmen's Compensation (page 189, April JOURNAL)

The Reference Committee approved unanimously the report of the Special Committee on Workmen's Compensation, which included the following recommendations:

1. That under proper auspices, closer cooperation be maintained between the Society and the Division of Workmen's Compensation of the Department of Labor and Industry for the purpose of improving the quality of medical testimony.
2. That the component societies arrange for instructional courses or lectures on Evaluation of Disability.

The Reference Committee wishes to take this opportunity to extend its sincere thanks for the work which the members of this committee have contributed to this important subject.

Chronically Ill (page 190, April JOURNAL)

The report of the Special Committee on Chronically Ill was considered and approved unanimously, including the following recommendation:

Continued and renewed efforts to stimulate the formation, and to support the operation, of committees on the chronically ill in all component societies.

The Reference Committee wishes to take this opportunity to extend its sincere thanks for the work which the members of this committee have contributed to this important subject.

The following, from the supplemental report of the Board of Trustees, were presented to Reference Committee "E" for consideration:

Principles of Approach to Specialty Services (page 40, these Transactions)

The Reference Committee unanimously approved this referral from the Board of Trustees, which included the following recommendation:

To this end the Board of Trustees recommends that the House of Delegates authorize it to convene such general meeting or meetings as have been described, inviting the specialty societies concerned, the Hospital Association, Medical-Surgical Plan, and Hospital Service Plan to send duly accredited representatives.

Blood Bank Commission (page 40, these Transactions)

The Reference Committee unanimously approved the referral on Blood Bank Commission.

Lengthy discussion from the floor and the Reference Committee developed the idea that legislation for control and operation of the blood banks throughout the state under rigid regulations of the medical profession should be encouraged.

Old Age Assistance (page 39, these Transactions)

The referral was unanimously approved as presented.

The Reference Committee wishes to thank the members of the Board of Trustees for their consideration and diligence in following through on these controversial subjects, and wishes to commend them on the decisions so far reached.

The following resolutions were referred to Reference Committee "E" for consideration:

English as a Factor for Medical Licensure (page 58, these Transactions)

This resolution from the Bergen County Medical Society was approved unanimously.

Disability Determination Under Society Security (page 8, these Transactions)

The Reference Committee felt this resolution, presented by Dr. Henry A. Brodkin, a delegate from Essex County, was mandatory as presented—

"*Resolved*, that each county be *instructed* to establish . . ."

Your Reference Committee feels that the purpose of the resolution is good. However it should not be mandatory upon the counties, but rather permissive. We recommend, with the permission of the sponsor of the resolution, that the opening sentence of the last paragraph read:

"*Resolved*, that it be suggested to each county society that it establish a list of physicians to whom such applicants may be referred by their physicians for a medical report to the Office of Disability Determination of the O.A.S.I. that the applicant is or is not permanently and totally disabled and can no longer engage in remunerative employment."

Classified Telephone Directory Listings (page 57, these Transactions)

This resolution, presented by the Bergen County Medical Society, was unanimously approved by the Reference Committee.

Corporate Practice of Medicine (resolutions from Monmouth and Burlington (page 196, April JOURNAL), and identical resolutions from Bergen and Essex Counties)

The resolutions from the Monmouth, Burlington, Bergen, and Essex County Medical Societies were approved unanimously as presented.

Doctors of Osteopathy (page 196, April JOURNAL)

This resolution, presented by the Bergen County Medical Society, was approved unanimously by the Reference Committee.

Essay Contests (page 197, April JOURNAL)

This resolution, from the Union County Medical Society, was approved unanimously as presented.

Crippled Children (page 57, these Transactions)

This resolution, presented by the Passaic County Medical Society, was read and studied at length. After a good deal of discussion from the floor and among the Committee members, it was found to be too ambiguous. In consequence the Committee voted unanimously to reject the resolution and expressed the hope that it might be presented in the future with more concrete information as to what is desired.

Nursing Assistants (page 58, these Transactions)

This resolution, presented by the Union County Medical Society, was discussed very vigorously and at great length. Under "Resolved," paragraph 1. was changed with the consent of representatives of the Union County Medical Society to read:

> "*Resolved*, 1. That The Medical Society of New Jersey look favorably upon such a program and that a special committee be appointed from the members of The Medical Society of New Jersey by the Board of Trustees to confer severally with the state department of education and representatives of the nursing profession to explore the possibility of establishing such a program of courses."

The Reference Committee rejected paragraphs 2. and 3. under "Resolved," with the consent of the representatives of the Union County Medical Society.

Social Security for Physicians (page 7, these Transactions)

This resolution, as presented by Dr. Arthur Bernstein, a delegate from the Essex County Medical Society, was considered and rejected as written because it was thought that at this time, when greater support for the Jenkins-Keogh bill is being mustered, that perhaps taking this poll might weaken our strategic position regarding the passage of the Jenkins-Keogh bill. The Committee recommends that if a Jenkins-Keogh type of bill fails of adoption this year, the poll might with advantage be taken subsequently.

Board of Ophthalmic Surgery (page 58, these Transactions)

This resolution, offered by the Mercer County Medical Society, was approved unanimously.

The Reference Committee wishes to take this opportunity to thank our secretariat for their diligence, excellent cooperation, and fine workmanship which they have displayed at this time, in keeping with the tradition carried on for many years in our organization.

Action: Pages 18 and 19

REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

John J. Torppey, M.D., Chairman

Advisory Committee to the Woman's Auxiliary (page 185, April JOURNAL)

The reference committee accepts with thanks the report of the Woman's Auxiliary Advisory Committee. The new projects undertaken this year are commendable. We are greatly appreciative of the cooperation, service and assistance of the Woman's Auxiliary.

Annual Meeting Committee (page 184, April JOURNAL)

The report of the Annual Meeting Committee and its recommendation—"That the 195th annual meeting of The Medical Society of New Jersey be held at Haddon Hall, Atlantic City" is approved. We wish to thank the committee and to commend them for the excellent work done in arrangements for this convention.

Scientific Program Committee (page 184, April JOURNAL)

The Committee accepts the report of the Scientific Program Committee. They have produced an unusually interesting and diversified program for which we extend our thanks and appreciation.

Scientific Exhibit Committee (page 184, April Journal)

We accept the report of the Scientific Exhibit Committee. This committee is to be congratulated for the complete planning of the exhibits and the integration with the scientific program.

Action: Page 20

REFERENCE COMMITTEE ON RESOLUTIONS AND MEMORIALS

Runkle F. Hegeman, M.D., Acting Chairman

The Reference Committee on Resolutions and Memorials met at 11:00 a.m., Sunday, April 28, 1957.

Honorary Membership (page 185 April JOURNAL)

There were no candidates for Honorary Membership.

Emeritus Members: (page 182, April JOURNAL, and page 43, these Transactions)

All nominations for Emeritus Membership were acted upon favorably.

Action: Page 20

REFERENCE COMMITTEE ON CONSTITUTION AND BY-LAWS

Lorrimer Armstrong, M.D., Chairman

The reference committee met at 11:00 a.m., Sunday, April 28, 1957, Haddon Hall, Atlantic City, with a full committee present. The business of the committee was first, to consider Article VI, Board of Trustees—proposed amendment to the Constitution, which had its first reading at the final session of the House of Delegates at the 1956 meeting of The Medical Society of New Jersey; second, revision of the Constitution as presented to the first session of the House of Delegates of the 1957 meeting.

Article VI—Board of Trustees (page 195, April JOURNAL)

The amendment to the Constitution, Article VI, pertaining to the Board of Trustees, was brought up for discussion. It was moved, seconded, and carried that the committee recommend the adoption of this proposed amendment.

Revision of Constitution (page 49, these Transactions)

The matter of the revision of the Constitution was discussed. Under the revision proposed by the Standing Committee on the Revision of Constitution and By-Laws, the committee recommended the following:

Article I—Name—The reference committee approves this article as presented.

Article II—Purposes—The reference committee approves this article as presented.

Article III—Component Societies—The reference committee approves this article as amended.

Article IV—Organization of the Society
Section 1—Composition
Section 2—Fellows
Section 3—Officers

The reference committee approves these three sections as presented.

Section 4—Delegates (a) Apportionment and Election.

Amend the second sentence to read: Each delegate shall be elected for a period of three (3) years.

The proposed second sentence shall become the third sentence: Each component society shall be entitled to at least three (3) delegates.

Delete the balance of the section as proposed.

Section 4—(b) Reapportionment
Section 4—(c) Delinquency
Section 4—(d) Vacancy
Section 4—(e) Alternates

The Reference Committee—with the consent of the Revisions Committee, four members of which were present at the meeting of the Reference Committee—recommends that this item be further amended as follows:

Original amendment

Each component society shall elect, at any meeting prior to March thirty-first of the fiscal year, alternate delegates in number equal to the number of regular delegates. A regular delegate, if unable to attend any meeting of the House of Delegates, shall so inform the secretary of his component society who shall arrange the assignment of the delegate's credentials to an alternate. An alternate, when serving, shall have all the rights and privileges of a regular delegate; and, when registered and seated in the House of Delegates, shall retain his seat during that entire meeting.

Further amendment

Each component society shall elect, at any meeting prior to March thirty-first of the fiscal year, alternate delegates in number equal to the number of regular delegates. A regular delegate, if unable to attend any meeting of the House of Delegates, shall so inform the secretary of his component society who shall arrange the assignment of the delegate's credentials to an alternate. An alternate, when serving, shall have all the rights and privileges of a regular delegate.

A regular delegate, if unable to attend a session of any meeting of the House of Delegates, may inform the secretary of his component society who shall arrange the assignment of the delegate's credentials to an alternate. An alternate, when registered and seated in the House of Delegates shall retain his seat during the remainder of the meeting.

Section 5—Members of Component Societies
Section 6—Emeritus Members
Section 7—Honorary Members
Article V—House of Delegates
Section 1—Composition

Section 2—Speaker

While the Reference Committee approved the intent of the proposed amendment to have a speaker for the House of Delegates, it felt that the method of selection of such speaker should not be binding upon the President, but rather that he should have the privilege of appointing a speaker if he so desires. Therefore, the Reference Committee recommends that this section read as follows:

Original amendment

A Speaker shall be elected by ballot at the second session of the House of Delegates at each annual meeting. He shall be a member of this Society. His sole duty shall be to preside at the

sessions of the House of Delegates, and he shall not have the power to appoint committees. The term of the speaker shall be for one (1) year.

Recommended amendment

The President shall have the power to appoint a Speaker of the House of Delegates at each annual meeting. The Speaker shall be a member of this Society, and his sole duty shall be to preside at the sessions of the House of Delegates. He shall not have the power to appoint committees.

Article VI—Board of Trustees

Inasmuch as Article VI has already been brought up for final reading it will not be a part of this section of the report on the revision of the Constitution.

Article VII—Judicial Councilors
Article VIII—Meetings
Section 1—Annual Meeting
Section 2—General Session
Section 3—Sections
Article IX—Officers
Section 1—Term of Office
Section 2—Election
Article X—Funds and Expenses
Section 1—Finances
Section 2—Incurring Expense
Article XI—Seal
Article XII—Amendments to the Constitution

Action: Pages 20 to 25

ANNUAL AND SUPPLEMENTAL REPORTS

TREASURER'S REPORT

(Reference Committee "B")

JESSE McCALL, M.D., Newton

BALANCE SHEET—APRIL 26, 1957

ASSETS

Cash:		
First National Iron Bank of Morristown:		
General checking account	$110,133.86	
Permanent capital fund savings account	3,565.25	$113,699.11
First Mechanics National Bank, Trenton:		
Executive Office revolving account		10,000.00
Savings Accounts:		
Bloomfield Savings Bank, Bloomfield	$ 11,103.38	
Howard Savings Institution, Newark	11,149.70	
Morris County Savings Bank, Morristown	902.64	
Montclair Savings Bank, Montclair	10,457.44	
Plainfield Trust Company, Plainfield	5,075.25	38,688.41
Savings and Loan Accounts:		
Guardian Savings and Loan, Atlantic City	$ 10,000.00	
Midtown Savings and Loan, Newark	10,000.00	
Monroe Savings and Loan, Newark	10,000.00	
Police Savings and Loan, Newark	10,457.54	
Roma Savings and Loan, Trenton	10,466.17	50,923.71
Total Cash		$213,311.23
Accounts Receivable		9,139.03
Inventory Maternal Welfare Record Books at cost (contra)		3,338.00
Investments, U. S. Savings Bonds		27,500.00
Land, Buildings and Equipment (contra)		111,554.43
Deferred Expense		42.32
Total Assets		$364,885.01

LIABILITIES AND SURPLUS

Employees' Payroll Deductions	$ 924.30
A.M.A. Dues Payable	950.00
Assessments Collected, Applicable to 1957-58	110,760.41
House Committee Reserve	2,337.78
Annual Meeting Reserve	16,623.85
A.M.A. Dues Collection Reserve	381.99
Membership Directory Reserve	530.00
JOURNAL Reserve	9,806.04
Land, Buildings, and Equipment (contra)	111,554.43
Maternal Welfare Record Books Reserve (contra)	3,338.00
Due to Permanent Capital Fund	3,000.00
Budget Accounts Payable to May 31, 1957	34,106.55
Surplus	70,571.66
Total Liabilities and Surplus	$364,885.01

CASH DIVISION

General Fund	$206,745.98
Permanent Capital Fund	3,565.25
Medical Student Loan Fund	3,000.00
Total	$213,311.23

PERMANENT CAPITAL FUND

Cash	$ 3,565.25
Investments	8,500.00
Due from General Fund for Bonds Redeemed	3,000.00
Total	$ 15,065.25

MEDICAL STUDENT LOAN FUND

Cash	$ 3,000.00

STATEMENT OF RECEIPTS AND DISBURSEMENTS FOR FISCAL YEAR 1956-57

June 1, 1956 — April 26, 1957

RECEIPTS

Cash on Hand, June 1, 1956			$185,857.78
Assessments:	A.M.A. Dues	State Dues	Total
Atlantic County	$ 3,750.00	$ 5,300.00	$ 9,050.00
Bergen County	11,642.50	19,337.50	30,980.00
Burlington County	2,150.00	3,010.00	5,160.00
Camden County	7,525.00	10,865.00	18,390.00
Cape May County	875.00	1,295.00	2,170.00
Cumberland County	1,675.00	2,585.00	4,260.00
Essex County	31,200.00	47,367.50	78,567.50
Gloucester County	1,650.00	2,415.00	4,065.00
Hudson County	12,500.00	18,697.50	31,197.50
Hunterdon County	1,000.00	1,470.00	2,470.00
Mercer County	8,512.50	11,920.00	20,432.50
Middlesex County	6,725.00	9,662.50	16,387.50
Monmouth County	5,400.00	8,885.00	14,285.00
Morris County	5,150.00	7,457.50	12,607.50
Ocean County	1,300.00	1,820.00	3,120.00
Passaic County	10,975.00	18,510.00	29,485.00
Salem County	1,225.00	1,700.00	2,925.00
Somerset County	2,225.00	3,155.00	5,380.00
Sussex County	950.00	1,400.00	2,350.00
Union County	12,625.00	18,040.00	30,665.00
Warren County	875.00	1,325.00	2,200.00
Total Assessments	$129,930.00	$196,217.50	$326,147.50
A.M.A. Dues Refunds			213.50
JOURNAL Advertising, net			39,822.36
Annual Meeting Exhibits			17,204.85
Interest			2,834.24
Sale of Maternal Welfare Books			872.90
Rents			585.00

Sale of Equipment	135.00	
Payroll Deductions	924.30	
Refunds of Budget Expenses	511.26	
Janitorial Services	15.00	
A.M.A. Dues Collection	1,405.01	
Membership Directory	530.00	
U. S. Savings Bonds Redeemed	3,000.00	
Miscellaneous	181.07	
Total Receipts		$394,381.99
Total		$580,239.77

DISBURSEMENTS

Budget Accounts:			
A- 1—Executive Salaries		$ 33,671.86	
A- 2—Executive Office Salaries		24,057.51	
A- 3—Executive Office Expenses		1,376.50	
A- 4—Executive Travel		861.38	
A- 5—House Maintenance		25,511.34	
A- 6—Treasurer		2,341.53	
A- 7—Finance and Budget		32.13	
A- 8—Secretary		2,320.54	
A- 9—Salary Taxes		1,360.48	
A-10—Insurance		1,480.43	
B- 2—JOURNAL Office Expenses		423.10	
B- 3—JOURNAL Office Travel		23.26	
C- 1—Welfare		610.00	
C- 2—Legislation		3,007.11	
C- 3—Public Health		1,082.03	
C- 4—Public Relations		4,371.70	
C- 5—Medical Practice		649.09	
D- 1—President and Other Officers		3,160.16	
D- 2—A.M.A. Delegates		7,791.91	
D- 3—Woman's Auxiliary		6,544.33	
D- 5—Liaison Committees		69.80	
D- 6—Membership, Directory, Physicians Placement		1,044.52	
D- 7—Emergency Medical Service, Civil Defense		15.50	
D- 8—American Medical Education Foundation		25,000.00	
E- 1—Board of Trustees		1,412.72	
E- 2—Contingent	$ 3,017.53		
Medical Service Administration	5,000.00	8,017.53	
E- 3—Judicial Council		612.61	
E- 4—Legal		1,693.38	
Total Budget Accounts			$158,542.45
Accounts Payable, May 31, 1956			10,796.55
JOURNAL Publication			34,475.85
Annual Meeting			5,819.30
JOURNAL Commissions			3,011.98
Janitorial Services			80.00
A.M.A. Dues Collection			1,505.01
Assessments Refunded			507.50
A.M.A. Dues			129,193.50
Maternal Welfare Record Books Purchased			3,640.00
House Committee Reserve			11,474.20
Prepaid Budget Expenses for 1957-58			14,042.32
Budget Expenses for 1955-56			405.13
Total Disbursements			$373,493.79
General Cash Balance, April 26, 1957			206,745.98
Total			$580,239.77

BOARD OF TRUSTEES

SUPPLEMENTAL REPORT

C. Byron Blaisdell, M.D., Chairman, Asbury Park

Subsequent to the presentation of the annual report of the Board of Trustees, published in the April JOURNAL, the items below were considered at meetings of the Board and are referred to the House of Delegates for consideration.

MEDICAL LEGAL TESTIMONY
(Reference Committee "A")

1. *Malpractice Testimony*

The 1956 House of Delegates adopted a resolution calling for a committee to be set up to study the problem of malpractice, and to make a report with detailed plans for the construction and operation of the mechanism to the 1957 House of Delegates. The following report was received by the Board of Trustees from the Special Committee on Medical-Legal Testimony, Dr. Marcus H. Greifinger, Chairman:

The Joint Committee on Medical-Legal Testimony, composed of representatives of the Medical Society and the Bar Association, met several times during the year.

The primary purpose of the last meeting in March was to decide whether, in the opinion of the representatives of the Bar Association and of The Medical Society of New Jersey some practical plan of operation could be evolved to effectuate the proposal that a joint committee of the two organizations be set up to pass upon the merits of contemplated malpractice cases. In the original concept, attorneys would be invited to submit their cases to the committee, on a voluntary basis, for evaluation. If the committee felt there was no merit in the case it would so advise, in the expectation — though not in the assurance—that under the circumstances the attorney for the plaintiff would not proceed. If the committee felt that the case had merit, it would so declare and would use its influence to assist the attorney for the plaintiff to get proper medical testimony if such were not readily forthcoming.

In the discussion which ensued points of criticism of the proposal were examined. These points of criticism had arisen out of a previous conference attended by representatives of the Committee on Medical Defense and Insurance, the chairman of the Judicial Council, the Presidential officers of The Medical Society of New Jersey, and representatives of the Medical Society's insurance carrier. They included:

(1) Opposition by U.S.F. & G. (the insurance carrier) to the proposal, as hostile to its role in providing protective insurance for members of The Medical Society of New Jersey.

(2) Opposition based upon the fact that the opinions of the joint committee could not be made binding upon either plaintiff or his counsel, with the result that counsel might nevertheless proceed, or in disapproved cases, refusing to proceed, might be dismissed by the plaintiff who would then have recourse to other more willing counsel;

(3) Opposition based upon the contention that in cases declared by the committee to have merit, settlement would become more difficult and more costly.

Recognizing these points of opposition as being substantial and formidable, the committee explored the possibility of dealing with the problem by some other means. Many devices were offered and discussed, but against all, three considerations prevailed:

(1) The objection of the insurance carrier would still hold;

(2) Any plans setting up panels of physicians to serve at the call of the Society, or of the court, would be invasive of the individual physician's right freely to choose to testify or not; and

(3) No plan could be drawn up which would be made binding upon the plaintiff or his counsel.

Finally, by unanimous agreement the joint committee declared: "This committee has explored all seemingly feasible approaches to solution of the problem and can arrive at no workable solution." The joint committee therefore agreed to recommend that the proposal be abandoned.

The recommendation of the joint committee was approved by the Board of Trustees.

2. *Workmen's Compensation Testimony*

Because its time was taken up almost exclusively with testimony in malpractice cases, the special committee requested, and the Board of Trustees approved, that the "study of medical testimony in compensation courts on a statewide basis" be held in abeyance and referred to next year's committee.

3. *Codes of Standards of Practice*

The 1956 House of Delegates adopted a resolution calling for the appointment of a committee to work in liaison with a committee of the New Jersey State Bar Association to formulate a code "which is to be presented and voted upon at the next annual meeting of this Society." The matter was referred to the Special Committee on Medical-Legal Testimony.

The special committee requested permission to defer its report until such time as it can be completed by the committee next year. Because the time this year was taken up almost exclusively with testimony in malpractice cases, it was not possible to give adequate time to carrying out the directive contained in the resolution. The Board of Trustees approved the request of the special committee.

NOMINATIONS TO BOARD OF TRUSTEES OF MEDICAL-SURGICAL PLAN OF NEW JERSEY

(Reference Committee "C")

The Board of Trustees of The Medical Society of New Jersey received the following nominations for membership on the Board of Trustees of Medical-Surgical Plan of New Jersey with the request that they be submitted to the House of Delegates:

Charles W. Barkhorn, M.D.
Irving P. Borsher, M.D.
Harry N. Comando, M.D.
Patrick H. Corrigan, M.D.
William F. Costello, M.D.
Joseph P. Donnelly, M.D.
Joseph I. Echikson, M.D.
Joseph M. Keating, M.D.
Arthur W. Lunn
Paul Mecray, Jr., M.D.
Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.
Edward W. Sprague, M.D.
John S. Thompson
Thomas J. White, M.D.
Carl K. Withers

NOMINATIONS TO BOARD OF GOVERNORS OF MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY

(Reference Committee "C")

The Board of Trustees of The Medical Society of New Jersey received the following nominations for membership on the Board of Governors of Medical Service Administration of New Jersey with the request that they be submitted to the House of Delegates:

Harry N. Comando, M.D.
William F. Costello, M.D.
Arthur W. Lunn
Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.
Edward W. Sprague, M.D.
John S. Thompson
Thomas J. White, M.D.

MEDICARE PROGRAM RADIOLOGIC AND PATHOLOGIC SERVICES

(Reference Committee "C")

From The New Jersey Society of Clinical Pathologists and the Radiological Society of New Jersey

Whereas, The Medical Society of New Jersey has declared that the practice of Pathology (Radiology) is the practice of medicine; and

Whereas, pathologic (radiologic) services may be rendered in or outside of a hospital; and

Whereas, in hospitals such pathologic (radiologic) services can be performed only by or under the supervision of physicians; and

Whereas, The Medical Society of New Jersey has contracted for the physicians of the State of New Jersey with the Department of Defense to supply medical services to dependents of the Uniformed Forces under Public Law 569 of the 84th Congress (otherwise known as the Dependents' Medical Care Act); and

Whereas, certification of medical services rendered can only be made by physicians; be it therefore

Resolved, that The Medical Society of New Jersey hereby declares that pathology (radiology) is a medical service under the terms of the contract which has been negotiated between the Medical Society and the Department of Defense and as set forth in Contract No. DA-49-007-MD-831, dated November 30, 1956, issued by the Department of Defense in compliance with the Dependents' Medical Care Act, and fees for such services wherever rendered, must be paid to the physicians rendering the services.

The above resolution — received from both The New Jersey Society of Clinical Pathologists and the Radiological Society of New Jersey—was considered by the Trustees and referred to the Special Committee on Medicare, with instructions to reply and explain the present situation. The Committee replied as follows: "Your attention is called to the New Jersey schedule of allowances for physicians' fees. These pages identify the fees which will be paid to pathologists (radiologists) for their respective services performed, upon submission of the proper form, DA-1863 to the fiscal agent."

OLD AGE ASSISTANCE

(Reference Committee "E")

The 1956 House of Delegates adopted a resolution urging that an attempt be made to have the law in New Jersey changed in order to provide for the direct payment of physicians for medical services rendered welfare clients.

The Subcommittee on Medical Practice, to which the resolution was referred by the Board of Trustees, reported that effective July 1, 1957, under an amendment in Federal law, a new fiscal arrangement will be created whereby physicians and all other vendors of medical services and materials will receive direct payment for services rendered and materials supplied.

At the request of the Bureau of Assistance of the State Department of Institutions and Agencies, a special committee was appointed by the President, with the approval of the Board of Trustees, to assist the Bureau in the development of medical care plan—a plan which can be administered with facility, which will assure quality of service, which will provide reasonable administrative controls on quantity of service, and will guarantee a level of allowances or fees that the body politic, as well as the professional group concerned, will accept as reasonable.

BLOOD BANK COMMISSION
(Reference Committee "E")

The New Jersey Blood Bank Commission has taken a number of steps in furtherance of its program of expanding and coordinating the blood bank activities of the state. An all day Blood Bank Seminar was held in Newark last November, followed by a refresher course in blood grouping and blood bank technics at Rutgers University the following day.

Tentative conclusions were derived from the seminar, and the following general principles were established as a basis for future commission policy:

1. That blood should be provided as needed in sufficient amount for any foreseeable circumstances and with all possible safeguards to prevent mishap to recipients;
2. That the procurement, processing and administration of blood for purposes of transfusion are a part of medical practice and therefore a primary responsibilty of the medical profession;
3. That as an outgrowth of this responsibility the Blood Bank Commission, as official representative of the medical profession in blood banking matters, include in its scope the consideration of all technical, public health, and economic questions related to blood banking;
4. That among these questions the following matters are of specific immediate concern to the Commission:

A. Uniform standards of blood bank procedures for collection, storage, and processing of blood in accordance with N.I.H. requirements;

B. Reliable and accurate laboratory technics of typing and crossmatching to ensure maximum safety to patients;

C. Education of physicians regarding the use and abuse of blood transfusion in clinical practice with particular reference to wasteful and unnecessary transfusions;

D. Use of additive in blood (A and B substances, antihistaminics, etc.);

E. Training and refresher programs for blood bank technicians;

F. Inspection and supervision of blood banks, including commercial blood banks;

G. Organization of clearing house facilities on a county basis and eventually on a statewide basis for exchange of blood and blood credits;

H. Establishment and support of county blood bank programs for recruitment of blood donors, coordination of county blood bank programs with county Civil Defense Administration, coordination of blood bank program with hospital programs.

In extension of these policies, each county medical society has been requested to appoint a liaison representative to meet with the Commission. The Commission will meet with these representatives in the interests of improved coordination of activities on both state and county levels.

A proposed *Code of Regulations for Blood Banks* drawn up by Eugene Katzin for the use of the health authorities of Newark was reviewed by the Commission. With certain minor revisions the *Code* was approved for the City of Newark. It was agreed that the *Code* would satisfactorily serve any municipality within the state in which a need for such a code exists. This document covers not only principles of operation of blood banks according to N.I.H. standards but also sets forth specific recommendations regarding qualifications of blood bank directors, donor fitness standards, standards for protection of patients against mishap or other side-effects of transfusion, and other relevant matters.

It was further decided that the Commission recommend this *Code of Regulations* to the Board of Trustees as a possible basis for legislation to be worked out by the Medical Society in conjunction with the State Board of Health for purposes of control and supervision of all blood banks within the state. The same *Code* is to be submitted to the New Jersey Society of Clinical Pathologists with the recommendation that its provisions govern the activities of all members who are similarly concerned in blood banking.

The Board of Trustees on March 24 approved the report of the Blood Bank Commission. The recommendation relative to the *Code of Regulations* was approved without commitment at this time for the preparation of legislation if required.

PRINCIPLES OF APPROACH TO SPECIALTY SERVICES
(Reference Committee "E")

Negotiations were undertaken during past years by representatives of the Medical Society and the New Jersey Hospital Association in an attempt to arrive at a solution of disagreements between radiologists, pathologists and member-institutions of the New Jersey Hospital Association. A meeting was held on October 3, 1956. Purpose of the meeting was to present to the representatives of the Hospital Association the answers supplied by the

New Jersey Radiological Society and the New Jersey Society of Clinical Pathologists to a series of questions previously formulated by the representatives of the Hospital Association at an earlier meeting with representatives of The Medical Society of New Jersey (March 4, 1956). Mr. John W. Kauffman, for the Hospital Association, suggested another meeting at which the representatives of the Hospital Association would present their reactions. It was understood that the next meeting would be at the call of representatives of the Hospital Association, who would set the time and place after consultation with the Medical Society. No such meeting had been called by the time of the Board meeting on March 24.

Contact was therefore made with the New Jersey Hospital Association with a request that the promised meeting be held without further delay so that the policy or position of the Hospital Association could be reported to the House of Delegates. If such a meeting was not possible, it was requested that the position of the Hospital Association be submitted in writing.

At its meeting on March 24, the Board once again reaffirmed its action of 1947 in which it declared that the specialties of anesthesiology, pathology, physical medicine, and radiology are branches of the practice of medicine; and that it supports the contentions that:

1. The services of the four groups are specialties of the practice of medicine.
2. They should be paid for by Blue Shield and not Blue Cross.
3. The services of these specialists should be separately billed for and should not be included as part of a hospital bill.

The representatives of the Hospital Association proposed dates for a meeting with the representatives of The Medical Society of New Jersey which were too close to the dates of our Annual Meeting for practical purposes. Informed of this fact, they did not find it possible to prepare and submit the written report which was requested of them. Thus the matter stands.

In conjunction with this entire situation, The Medical Society of New Jersey has played the role of intermediator, dealing in succession and separately with representatives of the specialty groups, the Hospital Association, Medical-Surgical Plan of New Jersey, and Hospital Service Plan of New Jersey. The role has led to undeserved criticism for The Medical Society of New Jersey for not solving problems which are not directly within its powers to solve.

The Medical Society of New Jersey continues in the determination to advance these problems to solution. A more direct method of negotiation seems indicated. Therefore The Medical Society of New Jersey proposes to call a general meeting, or a series of meetings, of all interested groups, confronting around a conference table all the various representatives, so that all aspects of the problem can be openly explored, objections and refutations made and met, and solutions understood and agreed on by all concerned.

It is our conviction that by this method of direct, frank, and comprehensive discussion, all aspects of the problems involved could be aired and disposed of, and an ultimate acceptable agreement probably arrived at.

The Medical Society of New Jersey is keenly aware of the importance of the problem and of the difficulties attendant upon its solution. The Society will exert every effort, in collaboration with the specialty societies, to bring about a satisfactory solution.

RECOMMENDATION

The Board of Trustees recommends that the House of Delegates authorize it to convoke such general meetings as have been described, inviting the specialty societies concerned, the Hospital Association, Medical-Surgical Plan, and Hospital Service Plan to send representatives.

FALSE COMPLAINTS

(Reference Committee "D")

The Board of Trustees, earlier in the year, appointed a Special Committee on False Complaints—Dr. Daniel F. Featherston, Chairman—to study two recommendations as follows:

1. That the Society's legal department study the Bar Association bill to ascertain its possibilities from the standpoint of defending the medical profession.
2. That, should it be found feasible, the Medical Society inaugurate a program to effectuate a similar plan.

The Special Committee submitted the following report, which report was approved by the Board of Trustees at its meeting on April 27. The Board refers the report to the House of Delegates. This includes a communication dated November 29, 1956 from Mr. Robert M. Backes, Counsel to The Medical Society of New Jersey who states "it is my opinion that the legislation referred to informally as S-2-34 (Chapter 122 Laws of 1956) is applicable to doctors as well as other professional persons."

We therefore recommend the following program be established to implement the above:

1. It is suggested that the use of the counter suit made possible by Chapter 122 Laws of 1956 be established by State policy, the expense to be borne by The Medical Society of New Jersey at the request of the doctors involved in a suit under their professional liability policy.

2. Members of The Medical Society of New Jersey should be informed of the decision of the

Trustees in accepting or rejecting the program herein submitted by means of (a) an announcement in THE JOURNAL of The Medical Society of New Jersey, (b) an announcement in a newsletter put out by The Medical Society of New Jersey. (c) announcement should be made by the brokers of our professional liability policy, Faulhaber & Heard. (d) this should be the subject of one county meeting per year of each component society for the next several years.

3. A press conference announced and arranged for a news story that the Trustees and/or the House of Delegates of The Medical Society of New Jersey has accepted the above opinion and will put it into use for the protection of the doctors.

4. Suggest a speaker for the Bar Association meeting to present the program of The Medical Society of New Jersey as regards Chapter 122.

5. Suggest a speaker for the State Publisher's Organization meeting to present the program of The Medical Society of New Jersey as regards Chapter 122 and to point out our opinions why the amount of damages sued for in a malpractice suit should be kept out of the original press story. Expand the necessity of good reporting being required to present both sides of a question at the time of the original announcement. Raise the question of newspapers opening themselves to a libel suit on the publication of original announcements of malpractice suits where injury to professional reputation is involved.

Have material prepared for use at county level for presentation to County Bar Associations and County Publisher's Association to cover the same field suggested in the two above paragraphs with presentation by a speaker, preferably the County president or Chairman of the Judicial Committee or prominent members with a press release of the material presented to all county newspapers, the secretary of the County Medical Society to check back with the Board of Trustees to see when it is accomplished.

Top level conferences with officers of the Medical Society, officers of Bar Associations and representative judges in an attempt to persuade the legal corporation to rewrite their Canon of Ethics *re*: "Trial by Newspaper" New York *Times*, January 29, 1957. "Newspaper publications by a lawyer as to pending or anticipated litigation" on the ground that such publicity might interfere with a fair trial in the courts . . . "The N. Y. Bar Association has now revised Canon 20 in the affirmative direction. It spells out as unprofessional conduct the issuance of a public news release relating to any pending or anticipated civil action or proceeding or criminal prosecution, the purpose or effect of which may be to prejudice or interfere with a fair trial in the courts or with the administration of justice. . . . There is no interference with the constitutional guarantee of freedom of the press in this injunction, but there is a strengthening of another constitutional guarantee—the right to a fair trial." . . . The best way to protect the defendant from unfair and prejudicial press statements by lawyers or prosecutors is to stop the abuse at its source; and that is what Canon 20 attempts to do. If it doesn't succeed, it should be strengthened again.

We believe it could be feasible for the carrier of our professional liability policies to notify attorneys bringing malpractice suit when the suit is acknowledged of what the Medical Society's position is on Chapter 122 which would put the attorneys on notice to inform their clients of this hazard to them—the clients. We believe it would be feasible to also notify the person or persons bringing the suit by form letter of this fact.

BLUE CROSS ADMISSIONS

(Reference Committee "C")

The Board of Trustees approves a recommendation of Medical-Surgical Plan that the information contained in the following communication sent by the Insurance Committee of the Monmouth Memorial Hospital be referred to The Medical Society of New Jersey for transmittal to the membership:

An Insurance Committee has recently been appointed at Monmouth Memorial Hospital. This committee is now engaged in studying the problem of Blue Cross admissions, particularly as regards abuses and violations. The hospital frequently has a bed shortage. Unnecessary use of beds makes them unavailable for patients who really need them. The hospital administrator is frequently powerless to overcome this problem, particularly if the referring physician will not help in preventing these violations.

The Blue Cross contract states that an admission should be for treatment only. It permits diagnostic procedures in connection with treatment. Referring physicians should comply with this policy and are urged to discourage "diagnostic admissions," which are often disguised as treatment admissions. They are also requested to discourage diagnostic procedures during an authorized admission if they are not related to the condition or conditions under treatment.

It is anticipated that the existence of this committee will serve to discourage irregularities. The committee wishes to be fair in all controversial matters and will endeavor to discuss controversial cases with the referring physicians before reaching any decisions. The committee has no desire to interfere with the freedom of thought of the physician in treating his patient. But when the admission is under the Blue Cross Plan we are forced to give an opinion on these matters for the benefit of the hospital, the patients seeking treatment and the premium paying population. The hospital is paid a standard daily rate and additional unrelated diagnostic procedures are therefore absorbed by the hospital. Projected further, the additional cost will be reflected on the premium rates of the following year.

Your help is earnestly asked in making the Blue Cross Plan a workable one at Monmouth Memorial Hospital.

NOMINATIONS FOR EMERITUS MEMBERSHIP

(Reference Committee on Resolutions and Memorials)

The following additional nominations for election to emeritus membership have been received from the county medical societies:

ESSEX COUNTY

Henry C. Crossfield, M.D., West Orange; age 59
James R. Irwin, M.D., Sante Fe, California (formerly of Belleville); age 65

GLOUCESTER COUNTY

Henry L. Sinexon, M.D., Pitman; age 71

SOMERSET COUNTY

Elmore G. Brittain, M.D., Bound Brook; age 62

FINANCE AND BUDGET

(Reference Committee "B")

David B. Allman, M.D., Chairman, Atlantic City

The committee has reviewed the expenses and accounts thus far reported for the current year. It is the opinion of the committee that this has been a sound and satisfactory year.

JOURNAL PUBLICATION

The Finance and Budget Committee commends the Publication Committee for its continued excellent financial status. No budget appropriation was requested for 1956-57, and the committee makes no request for funds for 1957-58. It will again operate on the funds in its reserve account.

BUDGET FOR 1957-58

Below is a copy of the requested budget for 1957-58, which has the approval of your committee and the Board of Trustees.

1958 ASSESSMENT

Last year the *per capita* assessment needed to meet the adopted budget was approximately $43. The House of Delegates voted an assessment for 1957 of $35. Consequently, to operate the Society during the current year, it was necessary to use surplus funds. This has decreased the surplus account below the desired amount.

Your committee feels that it is desirable to maintain, at the beginning of each fiscal year, a surplus of approximately $100,000. Therefore, on the basis of 5,640 paid members for 1948, an assessment of $40 will be required to meet the proposed budget and to bring the surplus account up to the desired figure.

For your information, the committee points out that a recent report on dues in other state medical associations shows a low of $20 in South Carolina, a high of $120 in Nevada, and an average of $45.43 for the country.

Your committee approves, as does the Board of Trustees, that the 1958 assessment be $40 per member.

RECOMMENDATIONS

1. That the proposed budget for 1957-58, in the amount of $207,975.00, be approved.
2. That the 1958 assessment be $40 per member.

PROPOSED BUDGET FOR 1957-1958

A- 1	Executive Salaries	$ 44,558.00
A- 2	Executive Office Salaries	32,687.00
A- 3	Executive Office Expenses	2,500.00
A- 4	Executive Office Travel	1,980.00
A- 5	House Maintenance	25,788.00
A- 6	Treasurer	2,930.00
A- 7	Finance and Budget Committee	150.00
A- 8	Secretary	2,990.00
A- 9	Salary Taxes	1,810.00
A-10	Insurance	2,047.00
B- 1	JOURNAL Publication	None
B- 2	JOURNAL Office Expenses	500.00
B- 3	JOURNAL Office Travel	100.00
C- 1	Welfare Committee	800.00
C- 2	Legislative Committee	7,600.00
C- 3	Public Health Committee	1,200.00
C- 4	Public Relations Committee	7,500.00
C- 5	Medical Practice Committee	800.00
D- 1	President and Other Officers	4,500.00
D- 2	A.M.A. Delegates	7,500.00
D- 3	Woman's Auxiliary	7,000.00
D- 4	Medical Education Committee	100.00
D- 5	Liaison Committees	700.00
D- 6	Directory, Membership, Physicians Placement	8,750.00
D- 7	Emergency Medical Service, Civil Defense Committee	125.00
D- 8	American Medical Education Foundation	25,000.00
D- 9	Archives and History	250.00
D-10	Blood Bank Commission	200.00
D-11	Medical Defense and Insurance Committee	250.00
E- 1	Board of Trustees	3,500.00
E- 2	Contingent	5,000.00
E- 3	Judicial Council	750.00
E- 4	Legal Counsel	3,500.00
E- 5	Medical Service Administration	5,000.00
	TOTAL	$207,975.00

MEDICAL DEFENSE AND INSURANCE

(Reference Committee "D")

J. Wallace Hurff, M.D., Chairman, Newark

ACCIDENT AND HEALTH INSURANCE

We have again reached an all time high in the number of our accident and health policyholders under the group plan of accident and health insurance with the National Casualty Company. As of January 1st, 1957, 3,533 of our members are insured under the program as compared with 3,464 in 1956.

During the past year, claims were paid to 407 of our members with the highest amount paid to one individual of $7,200.00 and a total paid to all members of approximately one-quarter of a million dollars. Our review of the loss ratio would definitely indicate that our program of accident and health insurance is proceeding on a satisfactory basis.

The company's accustomed manner of prompt and liberal claim settlements is reflected in the fact that there have been no complaints received by the Insurance Committee and no requests for arbitration during the past year.

The National Casualty Company has served us with our accident and health insurance program since April 1933. We can look back with pride at this long period of time that we have been served by the National Casualty Company and the administrators of the plan, E. & W. Blanksteen of Jersey City. We experienced reduction in rate under the program in 1942 and various increases in coverage and expansions of the program since then, in keeping abreast of the times.

The National Casualty Company is again rated by Alfred M. Best & Company as A-Plus (Excellent) which is the highest rating that an insurance company can obtain from this insurance rating organization.

RECOMMENDATION

The committee is unanimous in its recommendation that we continue to endorse E. & W. Blanksteen as our Official Broker for accident and health coverage.

PROFESSIONAL LIABILITY INSURANCE

The report of your committee on medical liability insurance for the year 1956 is based on a ten-month experience due to the fact that we are now compiling statistics on a January to January basis, whereas, former reports covered the period from March to March. This change has resulted in the deletion of two months—January and February, 1956—from this report. However, these months were included in last year's report. We have estimated the number of claims reported on a twelve-month basis for the year 1956. The total number of claims reported in the ten-month period from March 1, 1956 to December 31, 1956 was 108. Estimated number of cases for twelve-month period 125. There has been no marked increase in claims reported during 1956 as compared with the year 1955. Dollar-wise, there was a moderate increase in potential liability on claims.

The table below reflects the picture on a county basis. We call to your attention that for the 10-month period from March 1, 1956 to December 31, 1956, 18 counties reported claims, 3 counties had no claims, for a total of 108 claims for the period.

Comparing this period with the twelve-month period from March 1, 1955 to March 1, 1956, 9 counties reported an increase in the number of claims, 10 counties reported a decrease in the number of claims, and 3 counties reported no change.

During the term of 9 years and 10 months from March 1, 1947 to December 31, 1956, all counties reported one or more claims, and a total of 957 claims were reported.

9 YEARS - 10 MONTH PERIOD - MARCH 1, 1947 to DECEMBER 31, 1956

	12-Month Period from March 1, to March 1									10 Mo. 3/1/56 to	9 Yrs.,
	1947	1948	1949	1950	1951	1952	1953	1954	1955	12/31/56	10 Mo.
Atlantic	4	0	1	3	0	1	1	3	4	5	22
Bergen	2	4	6	4	4	13	10	12	10	12	77
Burlington	0	0	0	0	0	0	0	0	2	1	3
Camden	4	2	1	1	2	1	0	4	8	1	24
Cape May	0	0	0	0	0	0	0	0	1	0	1
Cumberland	0	2	0	2	1	2	0	1	0	0	8
Essex	14	24	27	28	29	31	28	21	24	31	257
Gloucester	0	2	0	0	1	2	0	0	0	1	6
Hudson	7	7	20	12	15	19	11	13	21	9	134
Hunterdon	1	0	0	0	0	2	1	0	0	1	5
Mercer	0	3	3	7	6	2	3	7	11	2	44
Middlesex	2	7	4	6	4	8	9	2	8	6	56
Monmouth	2	6	11	6	3	5	7	5	7	13	65
Morris	3	1	2	2	2	1	3	1	4	1	20
Ocean	0	2	3	0	1	1	2	4	0	2	15
Passaic	5	11	12	16	12	8	12	13	12	10	111
Salem	0	0	0	2	3	0	0	0	1	1	7
Somerset	0	1	0	0	0	4	5	1	0	1	12
Sussex	1	0	1	2	0	0	0	0	0	1	5
Union	9	12	10	2	6	5	9	7	11	10	81
Warren	1	0	0	0	0	0	1	1	1	0	4
	55	84	101	93	89	105	102	95	125	108	957

This exhibit indicates a noticeable improvement in the southern counties and one county in the northern part of the state. However, this has been offset by the number of claims reported by Monmouth and Essex Counties.

Present experience indicates that one out of 4.1 doctors have reported claims during the past 9 years, 10 months. For the year 1956, we estimate that one doctor in 32 reported a claim.

The table below compares the types of claims reported for the 12-month period from March 1, 1955 to March 1, 1956, with 10-month period from March 1, 1956 to December 31, 1956.

TYPES OF CLAIMS REPORTED

	March 1, 1955 to March 1, 1956	Mar. 1, 1956 to Dec. 31, 1956
Obstetrics and Gynecology	14	8
Surgery	21	21
X-ray	4	0
Orthopedics	7	9
Eye, Nose & Throat	11	7
Anesthesia	9	9
Physiotherapy	1	4
Genitourinary	3	3
Psychiatry and Neurology	5	0
General Practice		
(a) Patient injured, result of falls	8	4
(b) Needles and injections	13	11
(c) Penicillin	1	0
(d) Improper or incomplete diagnosis	6	9
(e) Miscellaneous	15	15
Unclassified	7	8

Loss ratio from a specialty point of view changes from year to year. Our greatest security from a professional liability coverage standpoint lies in the overall protection of our profession where one group protects the other.

At the conclusion of 1956, the following rate changes affecting New Jersey were announced. An increase in premium charges between 14 and 17 per cent, depending on the territory and limits of protection, for doctors performing major surgery and anesthesia being placed on the same rate schedule as major surgery. The changes are in connection with a general rate increase affecting 43 states in various amounts ranging from 14 per cent to 100 per cent. The increase for New Jersey was in the lowest bracket quoted, indicating to your committee that the change was moderate compared with other states. Further, rate reductions were published affecting two classifications, (1) additional charge for physicians engaged in partnership practice reduced from 33 1/3 to 25 per cent; (2) reduction in additional premium charged under employer's policy for the employment of physicians. Your committee has been conscious of the claim frequency and severity of losses resulting from the performance of major surgery and the administration of anesthesia and our findings indicate the justification for the rate revision under these classifications.

During 1956, there has been a definite increase in amounts paid out for legal expenses. This is an indication that more doctors subject to professional liability claims are willing to stand up in court and fight their battle, and it is hoped that this trend will continue. This trend is very important from a public relations standpoint since it indicates that the doctor is no longer willing to subject himself or his insurance carrier to unjust claims.

It is not advisable for your committee to discuss the causes and prevention of malpractice suits, but we can, in general terms, enumerate a few points that should be called to your attention:

1. Accurate records, both in the office and the hospital are invaluable.
2. Consultation in all cases when justified.
3. In cases where a doctor deems it unwise to inform a patient of his true status, it is essential that some member of the family be notified, preferably in writing.
4. Accidents and complications are a general part of medicine, when they occur they should be recorded in the records.
5. Every doctor should report all potential claims as soon as possible and by so doing, the insurance carrier is enabled to investigate and evaluate a claim at an early date, and the doctor, in turn receives the benefit of the advices of their legal staff.

In conclusion, the year 1956 is by comparison about the same as 1955. It is hoped that this may indicate a leveling off of our liability experience. The doctor can contribute much to the success of our program by keeping foremost in mind the interests of the patient and exercising continuous vigilance in the practice of medicine.

RECOMMENDATION

Your committee is unanimous in its endorsement that we continue the services of Faulhaber & Heard, Inc., as our broker for professional liability coverage. This firm has been, for many years, of inestimable value to the committee.

MEDICAL EDUCATION

(Reference Committee "D")

M. H. Greifinger, M.D., Secretary

It was with deep regret that the Society learned of the sudden death of Dr. Gerald I. Cetrulo of Newark, who had for several years served as chairman of the Committee on Medical Education. Dr. Cetrulo's untimely death is a loss to the Medical Society and to his colleagues in the medical profession. Our deepest sympathy is expressed to his family in the loss of their loved one.

The following is based on a report of a committee meeting on February 1st, which was considered by the Board of Trustees at its March meeting:

The committee discussed a plan of regional courses based on the desires of the profession and financial limitation of any plan. It was the committee's recommendation to the Board of Trustees that a "Questionnaire on Postgraduate Courses" be addressed to the entire membership. It would be pointed out that inasmuch as during 1956-57 a very successful series of courses in many branches of medicine and basic sciences was conducted by the Seton Hall College of Medicine, the committee wished to ascertain the interest and desires of the profession in extending these—similar or other courses — under the same aegis to a greater variety of regional locations and hospitals throughout all sections of the state. Further, the purpose of the questionnaire would be to determine the course, the area, and the desire and interest of hospital staffs in this respect. The committee could, in turn, recommend and suggest a regional plan at no cost to the committee or the State Society. It was the consensus of the committee that in this manner it could best give expression to the desires of the membership at large, and best fulfill its own mission of stimulating or encouraging postgraduate education in the most expeditious means presently available.

It was the action of the Board of Trustees, in response to the above recommendation, that the information desired could be obtained by a questionnaire to the education committees of the county medical societies. The Board directed that this procedure be followed.

SUBCOMMITTEE ON LEGISLATION

(Reference Committee "E")

H. Hale Hollingsworth, M.D., Chairman, Clifton

The 1956-1957 Subcommittee on Legislation again adopted the county keyman system as the means of making clear the official position of The Medical Society of New Jersey. Bulletins, prepared by the Executive Officer, informed the keymen when action was necessary so that the legislators could be approached in their own counties, their support of the Society's position sought, and reasons given, clarifying that position. If time were short a letter, in the name of the keyman from his own county, was placed on the desk of the individual legislator.

The Subcommittee met in the offices of the Society in Trenton on June 27, 1956; twice more in 1956; and twice in 1957. The last meeting was on April 10, 1957. About 60 bills of the 1956 legislature and a like number of those of 1957 were discussed. Of the 1956 bills, several had been acted upon by the 1955-1956 Subcommittee. They were again placed on the agenda, either because other bills of similar or of identical import had been introduced, or because interested individuals or committees asked to be heard. Of the 1957 bills, a fairly large number were identical with bills of the 1956 legislature, and with few exceptions required little debate. Other bills, some new and some not so new needed prolonged examination. In a few instances much additional information was necessary.

In all its discussions, the Subcommittee had the benefits of the commentaries of the Legislative Analyst. Immediately after bills were introduced in either house he scanned them. This was to ascertain whether a bill affected physicians, individually or collectively; or if it had a direct or potential bearing on the practice of medicine or on public health. If any of these factors were present, he outlined the changes in existing law which were proposed, and the net effect such changes would produce. Obviously, some of his commentaries were prepared after much research.

REFERRED QUESTIONS

Several times during the year, topics were referred by the Board of Trustees for study and, later, report. One of the component societies had sent a resolution to the Board urging The Medical Society of New Jersey interest itself more actively in furthering the availability of the Medical Examiner system for counties which still had the coroner system. The Legislative Analyst found that existing law made it possible for any county to have a medical examiner or in some instances a county physician. The qualifications required and the powers conferred were the same in either case. In either case, the Board of Freeholders has authority to appoint such an officer.

Another study, relative to the definition of physician in the Medical Practice Act, was reported to the Board of Trustees, following the last meeting of the Subcommittee.

PREPARATION OF LEGISLATION

The bill for annual registration of physicians, the provisions of which had been approved by the 1955-56 Subcommittee in May, 1956, and, subsequently, by the Board of Trustees, was prepared in final form and approved by the Bill Drafting Commission late in the legislative year. In February, 1957, Senator Shershin introduced it in the Senate, at the request of the Chairman of the Subcommittee. It received second reading one week later and can now be called up for passage in the Senate.

Early this year, Assemblyman Fitz Maurice requested assistance in preparing a bill to prevent indiscriminate sale of tranquilizing drugs. At about the same time the Subcommittee on Public Health referred a report of the Special Committee on Conservation of Vision to the Subcommittee on Legislation. In the report the Special Committee expressed great concern because at least one of such preparations contained scopolamine in quantity sufficient to cause danger of precipitating glaucoma. At the request of the Subcommittee, the Legislative Analyst arranged conferences with representatives of the Department of Health, the Board of Pharmacy, and the Commission on Revision of Laws. The conferences, which Mr. Fitz Maurice also attended, resulted in Assembly Concurrent Resolution 44 which memorializes the U. S. Food and Drug Administration and asks that all these drugs be taken off the unrestricted list.

RECEPTION TO THE LEGISLATURE

After the Executive Officer had communicated many times with the President of the Senate, the Speaker of the Assembly, and with the office of the Governor, April 8, 1957, was agreed to as a suitable date, convenient to all. Accordingly invitations for them to attend a reception and supper in their honor were sent. After they had been mailed, however, it became necessary to recall them. The legislature had unexpectedly decided to recess on April 1, 1957, and not reconvene until six weeks later. It seems improbable that the reception can be held later this year.

NATIONAL LEGISLATION

A small committee, within the Subcommittee, was established to follow the events on the national scene. This committee, Dr. Ludwig L. Simon, Chairman; and Dr. Winton H. Johnson, and Dr. Charles L. Cunniff, has kept the Subcommittee well informed. The 85th Congress has scarcely gained momentum in its program but may be expected to push many measures of interest and importance later.

Late in the 84th Congress, the Subcommittee participated through its individuals in the strong protests against the Security Law amendment, H. R. 7225. Prior to final action in the Senate, the advisor to the Subcommittee and Chairman of the Board of Trustees, Dr. C. Byron Blaisdell, went to Washington where he conferred with Senator Case and was assured the Senator was opposed. After it passed the Senate, the bill was further opposed by letters to the President.

ROUTINE HEALTH EXAMINATION

(Reference Committee "E")

Robert E. Verdon, M.D., Chairman, Cliffside Park

The Special Committee on Routine Health Examination has fulfilled its function by submitting a method of conducting a screening physical examination to be done in the physician's office, which will detect abnormalities and determine functional capacities where necessary. The history form suggested is a modification of the Cornell Index to be completed at home by the patient, and submitted to the physician for study prior to the physical examination. This method has been approved by the Trustees of The Medical Society of New Jersey. A copy of all material has been sent to each county medical society. The intent is to have this material available for purchase by those who desire to do so.

The committee thanks Dr. Kenneth E. Gardner, not only for his interest but also for doing much of the ground work so necessary for this type of study.

SCHOOL HEALTH

(Reference Committee "E")

Neil Castaldo, M.D., Chairman, Cranford

The committee deliberated on the need of the school health program. The members were in agreement that the program of school health examinations must be flexible and by implication differ in scope according to the community to be served. For example, the needs for this service in rural, suburban, or urban centers would differ according to (1) the services available in the various medical clinics, and (2) the increasing number of school physicians, some of whom are being engaged more or less on a full time basis.

In consequence of its deliberations, the committee urged the following points as basic in a satisfactory school health program:

1. Parents should be encouraged to have school children examined at least once a year by a private or family physician.
2. Only children of indigent parents or parents who do not accept the responsibility of annual health examinations for their children by a private physician should be examined by the school physician.
3. Teacher cooperation is essential in discovering abnormalities and reporting them to the school nurse.
4. Corrective treatment for abnormalities should be performed by private physicians.
5. Follow-up by the school nurse is necessary to insure action by the parents to initiate treatment of abnormalities.
6. Athletes competing in interscholastic sports should be given a thorough physical examination.
7. All school employees should be encouraged to have annual physical examinations.
8. The services of a school psychologist is tantamount with the detection and prevention of mental and emotional illnesses.
9. Tenure of office with full pension benefits should be extended to include the school physician.

The points enumerated are in conformity with recommendations made in a report titled "School Health Policies" prepared by the Committee on School Health of the American Academy of Pediatrics. They were submitted to the Subcommittee on Public Health for consideration. The subcommittee was of the opinion that approval of these points at this time might be premature in view of the fact that certain members of the subcommittee were of the opinion that several of the points are in conflict with the "Four Point School Health Program" adopted by the Medical Society several years ago and presently in effect. The

subcommittee, therefore, directed that the Special Committee on School Health further consider these basic points and consult with the New Jersey Chapter of the American Academy of Pediatrics, and the Medical Division of the State Department of Education, and report back to the subcommittee at a subsequent meeting. This is the status of the matter at the time of the submission of this report, and is to be considered as a progress report of the Special Committee on School Health.

EMERGENCY MEDICAL SERVICE, CIVIL DEFENSE

(Reference Committee "D")

R. Winfield Betts, M.D., Chairman, Medford

This committee functions as a liaison agency between the Society and various organizations and agencies in an attempt to keep the Society informed on matters affecting it in the field of disaster medicine. A resume of some of the activities of the committee follows:

NEW JERSEY HOSPITAL ASSOCIATION

The committee met with the Special Committee on Disaster Planning of this association. Specific information of value was given to the association. Hospital disaster plans were reviewed and a model hospital disaster plan is being prepared. This will have its first trial at the Burlington County Hospital, Mount Holly. When it is satisfactory, this plan will be available to any hospital in the state for adaptation to its own needs.

Through THE JOURNAL, the committee circularized the membership of The Medical Society of New Jersey to learn of the status of disaster planning of the hospitals in the state.

NURSES' ASSOCIATION

The committee reviewed material for the advanced manual to be published by the State CD-DC. It corrected, revised, and offered suggestions in keeping with modern surgical practice for use in this manual.

DISASTER CONTROL ORGANIZATION

The Trustees received a request from Dr. Daniel S. Bergsma, Medical Director, New Jersey CD-DC, that The Medical Society of New Jersey co-sponsor, help design, and conduct training of individuals and teams to perform effectively during grave emergency and Civil Defense conditions. This is a big order, and a request for clarification and instructions has not been answered to date. Anticipating one of the Director's requests (training of ancillary personnel for manning the 200-bed FCDA emergency hospitals) the Chairman has received permission to use one of these units for training purposes and arrangements are being completed for suitable housing of the unit. When housed, it will act as a training center for setting up, breaking down, and for training of auxiliary personnel necessary to man this unit. It is hoped that the program developed here will be useful as a guide in establishing similar programs elsewhere, and perhaps be used as a center for training other South Jersey personnel. It is rumored that over 200 of these units are to be stored in this state. Obviously a hospital of any capacity is useless unless personnel familiar with its use and organization has received prior training.

Several other requests of the Director have been received by the committee and dispatched to the satisfaction of both parties. The most cordial of relations exist between the Official State CD-DC organization and The Medical Society of New Jersey.

LIAISON WITH COUNTY SOCIETIES

Numerous requests for information, clarification of areas of responsibility, for speakers at meetings, and for attendance in an official capacity at functions have been received and complied with in every case.

In compliance with a request from the Bergen County Medical Society, this committee represented The Medical Society of New Jersey at a conference with Governor Meyner, his Department of Defense staff, and representatives of the Bergen County Medical Society, the Pharmaceutical, Nurses', Dental, and Hospital Associations. This conference was productive of more potential benefits to the Civil Defense Disaster Control effort in this state than any others in the past five years. Dr. Bergsma has taken steps to obtain a full-time Medical Officer with military experience, whose primary activities will be to act as liaison between the state CD organization and the medical and allied professions. This has been an objective of this Society for many years. Several items of contention were aired and will be remedied in the near future.

OTHER ACTIVITIES

Members of this committee have digested reams of books, pamphlets, articles, papers, and other incidental material on the subject of disaster medicine. They have spent hours of time in travel and at meetings — in helpful conference and in disgust at our state of preparedness for disaster — civil or military. For this effort, and for their wholehearted cooperation the chairman wishes to thank them.

The following objectives are proposed by the committee for realization in the near future:

1. The sponsorship of an Advisory Council on Emergency Medical Service, Civil Defense by The Medical Society of New Jersey and the offer of the State Society Headquarters as a meeting place.

   Composition: This Council should include representatives from all relevant groups including nurses, osteopaths, chiropractors, veterinarians, dentists, first aid squads, *et cetera*.

Functions: To act in a purely advisory capacity on such matters upon which the Medical Director of CD-DC has requested advice and/or information, and to coordinate the work of the ancillary medical services into a well integrated effort for preparedness in this state.

Note: Purely as a matter of self-protection and in an effort to "save face" the Medical Society should take the initiative in formulating or sponsoring such a group. If we do not, it will be sponsored by some other organization, and we will be participating in a minor role, when we should take leadership in such an important field. If we do not do this, we will be in the position of "the tail wagging the dog." In large scale disaster we will be compelled to accept these services, why not properly coordinate them beforehand?

2. The publication in THE JOURNAL of The Medical Society of New Jersey of a section on disaster medicine as a regular feature.

This offer has been made to the State CD for two years, and has not been accepted. Yet this committee receives numerous requests from physicians interested in what is being done in other counties, in other states, and in the latest and best methods of therapy in disaster.

3. That each component county society be urged to establish a Committee on Emergency Medical Service, Civil Defense or on Disaster Control, and that at least one meeting a year sponsored by the county society be held on the subject of Disaster Medicine. It is further recommended that this committee make the most potent efforts to achieve cooperation between the members of the component society and organized civil defense activities at the local and county level.

4. That at the 1958 Annual Meeting a conference room be made available to this committee at which time it can meet with representatives of the county society committees and leaders in the civil defense field to discuss matters of mutual concern. This procedure is used with success at the A.M.A. conventions, and seems a more appropriate method than last year's abortive attempt to present a program at a General Session.

REVISION OF CONSTITUTION AND BY-LAWS

(Reference Committee on Constitution and By-Laws)

Louis F. Albright, M.D., Chairman, Asbury Park

Obviously the Constitution and By-Laws must state certain more or less enduring principles. On the other hand, it is not an immutable document and must be dynamic and geared to the changing circumstances under which The Medical Society of New Jersey operates and to the varying conditions which develop within the Society itself. Also certain provisions which initially seemed sound legislation and practice will prove over a period of years to be unsatisfactory or unworkable or both. Thus the Constitution and By-Laws must always be subject to evolution and change. Very properly our present Constitution contains provisions which make changes time-consuming and somewhat difficult. Consequently a piecemeal process of revision does not evolve a properly integrated Constitution or result in a smooth dovetailing of the multiple provisions of the By-Laws. These shortcomings of our existing Constitution and By-Laws have been rather obvious in the past several years.

During the annual session in 1956 it became apparent that the Standing Committee on Revision of Constitution and By-Laws might very properly undertake a substantial program of revision in the coming year in an effort to eliminate some of the ambiguous and conflicting provisions, and to attempt to bring our Constitution and By-Laws more in line with the current thinking of the membership as a whole. With this in mind Dr. Lewis C. Fritts, our President, on June 8, 1957, named a Committee on Revision of Constitution and By-Laws consisting of Dr. Albright, Chairman, and Dr. Gannon, Dr. Kump, Dr. Kustrup, Dr. Dodd, and Dr. Hollingsworth.

In its initial discussions, the committee felt that the most practical approach to the problem would be to submit a proposed revision of the Constitution at the 1957 Annual Meeting. If this was well received, then the committee felt it could, with some feeling of ultimate success, proceed to revise the By-Laws—properly to supplement and dovetail the revised Constitution—and present the revised Constitution and By-Laws for final adoption in 1958.

Preliminary work included several consultations, and correspondence with Mr. Edwin J. Holman of the Law Department of the American Medical Association. On the advice of Mr. Holman, we obtained and carefully reviewed the Constitution and By-Laws of a number of the state medical societies, including those of Ohio, California, New York, District of Columbia, and Pennsylvania. These latter were, in the opinion of Mr. Holman, the best of the present Constitution and By-Laws of any of the states. It is also interesting and somewhat gratifying to know that our own Constitution and By-Laws had also been

considered a satisfactory model for other states to use and was inadvertently included in the original group submitted by the American Medical Association for our study.

In a meeting at Trenton on February 10, 1957, the committee completed a draft of the revised Constitution. We felt that the document was as brief and concise as possible, that it was adequately formalistic, and that it was not cluttered up with many qualifying or procedural sections which should more properly be included in the By-Laws. We believed that the ambiguous and possibly conflicting statements of the previous Constitution were eliminated. A few entirely new conceptions of Constitutional regulation of our activities are included, such as that embodied in Article V, Section 2 which provides for a Speaker of the House of Delegates.

The President, Dr. Lewis C. Fritts, felt that this procedure of revision might be expedited if preliminary general discussions could be had in a Constitutional Convention at which all the counties were represented. Accordingly, all counties were asked to name two delegates to a Constitutional Convention, and this group met with our committee on March 17, 1957 in Trenton. Representatives were present from all counties except Cape May, Gloucester, Hudson, Ocean, and Sussex.

The revised Constitution was presented in great deail and very carefully and thoroughly studied by this Constitutional Convention. Some changes over and above those presented by the committee were suggested by the delegates, and since these were approved almost unanimously by the delegates they were included in the final draft of the revised Constitution. In its final form the revised Constitution received the almost unanimous approval of all members of the convention, both delegates and committee members. The single exception, I believe, was the vote on Article VI —Board of Trustees. The only dissenting votes were those of the two delegates from Essex County. It is this final draft of the revision of the Constitution which was so overwhelmingly approved at the Constitutional Convention on March 17 which is presented for first reading today.

Since Article VI—Board of Trustees—had its first reading at the annual session in 1956 and is therefore up for final reading and adoption now, we have not included any Article VI in the revision of the Constitution submitted. The reasons for this are obvious. It must come up for a final reading and adoption in this session regardless of any status it might have as part of the revised Constitution. I believe it will be less confusing if Article VI is acted upon separately, as it must be, and then included in the revised Constitution as finally adopted.

It is to be remembered then that this Article VI—Board of Trustees—is the only part of the Constitution which is up for final adoption in 1957. If this Article VI—Board of Trustees—should be rejected at this annual session of the House of Delegates then the old Article VI—Board of Trustees—on page 14 of the published Constitution, By-Laws, Charter of The Medical Society of New Jersey, amended up to September 14, 1956, will continue in force as *the* Article VI—Board of Trustees. The decision rests with this House.

It is to be noted that a proposed phrase—*"except in the case of elected Trustees,"*—in Article IX, Section 2, is contingent upon the adoption of Article VI. If the proposed Article VI is adopted, the proposed amendment to Article IX, Section 2, should be approved. If Article VI is to remain the same as at present, then the proposed phrase in Article IX, Section 2, must be stricken from the revision.

It was the unanimous opinion of the committee that the House of Delegates, which has considerably increased in size over the years, is becoming too large. Therefore, it was our recommendation that the House be reduced to nearly half by allowing *one* (1) *delegate for each thirty* (30) *members or major fraction thereof*. The Constitutional Convention in the majority disagreed, and the committee withdrew the proposed change. Our attitude on the matter, however, remains the same.

We of the committee feel that the revision proposed is a sound and well organized system of fundamentals. We consider it to be free of elements of unclearness or ambiguity. We consider it comprehensive and complete. It has the approbation of the delegates to the Constitutional Convention. It should prove a firm basis upon which to develop our By-Laws and procedural codes. We urge its adoption.

Last, but by no means least, the committee wishes to thank those untiring and very capable members of our Trenton staff, Mrs. Edith L. Madden and Mr. Richard J. Nevin, our Administrative Secretary and Executive Officer respectively, without whose assistance this work could not possibly have been accomplished. We are also greatly indebted to our legal advisor, Mr. Robert M. Backes of Trenton, who has made himself liberally available to us at all times and whose clearcut legal thinking is evident in many portions of my report. Also we wish to thank our own Dr.

Henry A. Davidson, who has done a tremendous amount of work in drawing up an entirely new and thoroughly renovated concept of what he believes our Constitution should embody as well as detailing many very sound thoughts in relation to our By-Laws and procedural codes which I am sure will save us many hours in next year's work on the By-Laws.

CONSTITUTION

Current

ARTICLE I—NAME

The name of this organization is "The Medical Society of New Jersey."

ARTICLE II—PURPOSE

The purposes of this society are:

To federate and organize the medical profession of the State of New Jersey;

To unite with similar organizations of other states to compose the American Medical Association;

To advance medical science, elevate professional standards, safe-guard the material interest of and promote friendly relations among members of the medical profession;

To educate the public in prevention of disease and the preservation of health; and, in general,

To render this profession most capable of serving humanity.

ARTICLE III—COMPONENT SOCIETIES

County medical societies that hold charters from this society shall be known, and referred to in the Constitution and By-Laws, as component societies.

ARTICLE IV—COMPOSITION OF THE SOCIETY

Section 1—Of Whom Composed

This society shall be composed of Fellows, Officers, Delegates, and members of Component Societies in good standing.

Section 2—Groups

(a) Fellows. The Fellows are the Ex-Presidents of the society.

(b) Officers. The Officers shall be a President, a President-Elect, two Vice-Presidents, a Secretary, a Treasurer, members of the Board of Trustees, and the Councilors.

Proposed

ARTICLE I—NAME

The name of this organization is "The Medical Society of New Jersey."

ARTICLE II—PURPOSES

The purposes of this Society are:

To federate and organize the medical profession of the State of New Jersey;

To unite with similar organizations of other states to compose the American Medical Association;

To advance the art and science of medicine, elevate professional standards, safe-guard the interests of, and promote friendly relations among, members of the medical profession;

To promote the betterment of public health; and to enlighten and direct public opinion in regard to the problems of medicine and health for the best interests of the people of New Jersey; and, in general,

To render the members of the Society most capable of serving mankind.

ARTICLE III—COMPONENT SOCIETIES

County medical societies that hold charters from this Society shall be known, and referred to in the Constitution and Bylaws, as component societies. There shall be no more than one component society in any county.

ARTICLE IV—ORGANIZATION OF THE SOCIETY

Section 1—Composition

This Society shall be composed of Fellows, Officers, Delegates, members, and associate members of component societies in good standing, and Emeritus Members. Honorary Members may be elected, but they shall not be members of the corporate body.

Section 2—Fellows

The Fellows are the Past-Presidents of the Society.

Section 3—Officers

The Officers shall be a President, a President-Elect, a First Vice-President, a Second Vice-President, a Secretary, a Treasurer, the elected members of the Board of Trustees, and the Judicial Councilors.

(c) Delegates. Delegates shall be chosen by and from the component societies, and shall be members of this society and of the House of Delegates for the period of time for which they are elected, subject to continuance of good standing in their respective component society, and further subject to their respective component society continuing in good standing in this society.

Section 3—Election of Delegates

(a) Apportionment. Each component society shall be entitled to one (1) delegate for each fifteen (15) members or major fraction thereof, to be elected at its annual meeting by a majority ballot of the members present; but, each component society shall be entitled to at least three (3) delegates. Each component society shall, at its annual meeting next following the adoption of this Constitution, elect delegates in 3 groups, for periods of 1, 2, and 3 years, respectively; and thereafter shall elect its delegates for periods of 3 years each.

(b) Reapportionment. In the event of subdivision of any of the existing counties of New Jersey and the creation of an additional component society, the delegates from the old and the new component societies shall be apportioned on the basis above provided, and the quota of the original component society of that district shall be correspondingly diminished.

(c) Delinquency. In the event that a component society becomes delinquent to this society, its entire delegation shall lose its status throughout the period of such delinquency.

(d) Vacancies. A vacancy shall exist in the delegation of any component society whenever one of its delegates ceases to be in good standing, or fails to attend two consecutive meetings (annual or special) except in case of illness, or resigns, or dies. When such a vacancy occurs in any component society, its secretary shall promptly so notify the secretary of this society, in writing; and, after acknowledgment of receipt of such notice, the component society shall, at a regular or special meeting, fill the unexpired term of such vacancy by election of a new delegate, by a majority ballot of the members present.

(e) Alternates. Each component society shall elect, at its annual meeting, an alternate delegate for each regular delegate, and the latter, if unable to attend the annual meeting (or any regularly called meeting) of this society, shall assign his delegate's card to an alternate. An alternate, when serving shall have all the rights and privileges of a regular delegate; and, when registered and seated in the House of Delegates, shall retain his seat during that entire meeting.

Section 4—Delegates

Delegates shall be chosen by and from the component societies, and shall be members of this Society and of the House of Delegates for the period of time for which they are elected, subject to continuance of good standing in their respective component society, and further subject to their respective component society's continuing in good standing in this Society.

(a) Apportionment and Election. Each component society shall be entitled to one (1) delegate for each fifteen (15) members or major fraction thereof, to be elected at any meeting prior to March thirty-first of the fiscal year by a majority ballot of the members present. Each component society shall be entitled to at least three (3) delegates. Each component society shall, at any meeting prior to March thirty-first of the fiscal year following the adoption of this Constitution, elect delegates in three (3) groups, for terms of one (1), two (2), and three (3) years, respectively; and thereafter shall elect its delegates for terms of three (3) years each.

(b) Reapportionment. In the event of geographic subdivision of any of the existing counties of New Jersey, and the creation of an additional component society, the delegates from the old and the new component societies shall be apportioned on the basis above provided.

(c) Delinquency. In the event that a component society becomes delinquent to this Society, its entire delegation shall lose its status for the period of such delinquency.

(d) Vacancy. A vacancy shall exist in the delegation of any component society whenever one of its delegates ceases to be in good standing, or neglects to attend a majority of the sessions of the House of Delegates at two consecutive meetings (annual or special). When such a vacancy occurs, the component society shall fill the unexpired term.

(e) Alternates. Each component society shall elect, at any meeting prior to March thirty-first of the fiscal year, alternate delegates in number equal to the number of regular delegates. A regular delegate, if unable to attend any meeting of the House of Delegates, shall so inform the secretary of his component society who shall arrange the assignment of the delegate's credentials to an alternate. An alternate, when serving, shall have all the rights and privileges of a regular delegate; and, when registered and seated in the House of Delegates, shall retain his seat during that entire meeting.

Section 4—Members of Component Societies

All members of component societies in good standing are hereby constituted members of this society and entitled to participate in all the privileges of general and scientific sessions.

Section 5—Members of Component Societies

All members of component societies in good standing are hereby constituted members of this Society and are entitled to full privileges.

Associate members of component societies in good standing are hereby constituted associate members of this Society, but they may not vote or hold office.

Section 7—Emeritus Membership

The emeritus membership group shall include physicians who have been members in good standing of a component county society for at least twenty (20) years, and who by reason of age or infirmity have retired from the active practice of medicine, or members of the society who have been disabled by reason of military service. They shall have all the privileges of membership except the right to vote and hold office, but their respective component societies shall not be assessed for such members provided they are carried as emeritus members in their component societies. The emeritus members shall not be included in the membership of a component county society when computing the number of delegates that such society is entitled to.

Section 6—Emeritus Members

Emeritus members shall be physicians who have been members in good standing of a component society for at least twenty (20) years, and who by reason of age or infirmity have retired from the active practice of medicine; or members of the Society who have been disabled by reason of military service. Nominations shall be submitted by the component societies, and emeritus membership shall be conferred by a majority vote of the House of Delegates. Emeritus members shall have all the privileges of membership except the right to vote and hold office, and their respective component societies shall not be assessed for such members provided they are carried as emeritus members in said component societies. Emeritus members shall not be included in the membership of a component society when computing the number of delegates to which such society is entitled.

Section 5—Honorary Members

Honorary members shall be physicians and surgeons who have attained distinction within the medical profession, or nonmedical persons who have rendered signal service to The Medical Society of New Jersey or who have attained special eminence in scientific fields other than medicine. Nominations shall be submitted by recognized medical groups to the Committee on Honorary Membership for approval or disapproval, and the committee's action shall be transmitted to the Board of Trustees by December first. Nominations approved by the Board of Trustees shall be officially sent to the component county medical societies at least three (3) months before the annual meeting at which action is to be taken, and the approval of a majority of the component medical societies shall be required to validate the nomination before it can be submitted to the House of Delegates. Nominees may be elected by a two-thirds vote of the House of Delegates provided the number of living Honorary Members does not exceed fifteen (15). Presentation of the honorary membership shall be made at the following annual meeting. Honorary Members shall have all the privileges of members, but shall not be members of the corporate body.

Section 7- Honorary Members

Honorary members shall be physicians who have attained distinction within the medical profession; or persons who have rendered signal service to The Medical Society of New Jersey, or who have attained special eminence in scientific fields other than medicine. Nominations shall be submitted by recognized medical groups to the Committee on Honorary Membership, and the committee's action shall be transmitted to the Board of Trustees by December first. Nominations approved by the Board of Trustees shall be officially transmitted to the component societies at least three (3) months before the annual meeting at which action is to be taken, and the approval of a majority of the component societies shall be required to validate the nomination before it can be submitted to the House of Delegates. Nominees may be elected by a two-thirds vote of the House of Delegates at the first session. Presentation of the honorary membership shall be made at the closing session of the House of Delegates. Honorary members shall not be members of the corporate body. At no time may the number of living honorary members exceed twenty-five (25).

Section 6—Guests

Any physician, resident or non-resident of New Jersey, may upon invitation of this society or its House of Delegates, become a Guest during the annual meeting, and shall thereby be accorded the full privileges of the scientific sessions.

NOTE

Deleate the Section on "Guests" from the Constitution as it has no bearing on the Article which deals with "Composition of the Society." It properly belongs in the Bylaws, Chapter III.

ARTICLE V—HOUSE OF DELEGATES

The House of Delegates shall be the legislative body, and shall consist of the Fellows, Officers and Delegates.

ARTICLE V—HOUSE OF DELEGATES

Section 1—Composition

The House of Delegates shall be the legislative body of this Society, and shall consist of the Fellows, Officers, and Delegates.

Section 2—Speaker

A Speaker shall be elected by ballot at the second session of the House of Delegates at each annual meeting. He shall be a member of this Society. His sole duty shall be to preside at the sessions of the House of Delegates, and he shall not have the power to appoint committees. The term of the speaker shall be for one (1) year.

ARTICLE VI—BOARD OF TRUSTEES

The committee has given no consideration to Article VI, inasmuch as it is presently in the process of possible revision in the House of Delegates. Final determination concerning Article VI is to be made by the House of Delegates in this session. Accordingly, Article VI of the Constitution will be such as is determined this year by action of the House of Delegates.

ARTICLE VII—COUNCILORS

The Councilors collectively shall comprise the Judicial Council which shall be the judicial body of the society. The House of Delegates shall organize five (5) councilor districts within the state. It shall elect one (1) councilor to represent each district from among the membership of each such district.

ARTICLE VII—JUDICIAL COUNCILORS

The Judicial Councilors collectively shall comprise the Judicial Council which shall be the judicial body of this Society. The House of Delegates shall organize five (5) councilor districts within the State. It shall elect one (1) Judicial Councilor from among the membership of each of the five (5) districts.

ARTICLE VIII—MEETINGS

Section 3—Time and Place of Annual Meeting

The time and place for said annual meeting shall be fixed by the House of Delegates for each succeeding year. The Board of Trustees may change the time and place when necessary.

ARTICLE VIII—MEETINGS

Section 1—Annual Meeting

This Society shall hold at least one meeting annually. The time and place for such meetings shall be fixed by the House of Delegates. The Board of Trustees may change the time and place when necessary.

Section 1—General Session

This society shall hold an annual meeting, during which there shall be at least one general session that shall be open to all registered members.

Section 2—General Session

During the annual meeting there shall be at least one general session that shall be open to all registered members and invited guests.

Section 2—Sections

The House of Delegates or the Board of Trustees may provide for division of the scientific work of the society into appropriate sections whenever necessity therefor arises.

Section 3—Sections

The House of Delegates or the Board of Trustees may provide for division of the scientific work of this Society into appropriate sections whenever necessity therefor arises.

ARTICLE IX—OFFICERS

Section 1—Term of Office

The Officers, except the Councilors and members of the Board of Trustees, shall hold office for one year, or until their successors are elected and installed.

ARTICLE IX—OFFICERS

Section 1—Term of Office

The Officers, except the Judicial Councilors and the elected members of the Board of Trustees, shall hold office for one (1) year, or until their successors are elected and installed.

Section 2—Election

The Officers shall be elected by the House of Delegates, by ballot on the second day of the annual meeting. No member shall be eligible to more than one office at the same time, except the President, President-Elect, and two (2) Vice-Presidents, Secretary and Treasurer, who by virtue of such offices are at the same time members of the Board of Trustees. A vacancy in office occurring between annual meetings may be filled *ad interim* by the Board of Trustees.

ARTICLE X—FUNDS AND EXPENSES

Section 1—Finances

Current expenses of this society shall be met by an annual per capita assessment upon the members of each component society; by donation; by sale of the society publications; and from miscellaneous revenue. During the annual meeting, funds may be appropriated by the House of Delegates for the expenses of the annual meeting, for publications, for expenses of officers and committees, but for no other purpose, unless authorized by a two-thirds vote of the members of the House of Delegates then present, and approved by the Board of Trustees.

Section 2—Incurring Expense

The Board of Trustees may incur any necessary expense *ad interim*.

ARTICLE XI—SEAL

The seal heretofore adopted and now in use shall continue, unless otherwise ordered, to be the Seal of The Medical Society of New Jersey.

ARTICLE XII—AMENDMENTS

This Constitution may be amended by a two-thirds vote of the members present at any annual meeting, provided the proposed amendments have been considered by the Committee on Revision of Constitution and By-Laws, and that they shall have been submitted in writing at a previous annual meeting, shall have been published in the JOURNAL of this society, and officially sent to each component society at least three (3) months before the annual meeting at which final action is to be taken.

Section 2—Election

The Officers shall be elected by ballot at the second session of the House of Delegates at the annual meeting. No member shall be eligible for more than one office at the same time, except the President, the President-Elect, the First and the Second Vice-Presidents, the Secretary, and the Treasurer, who by virtue of such offices are at the same time members of the Board of Trustees. A vacancy in office, *except in the case of elected Trustees, occurring between annual meetings may be filled by the Board of Trustees until the next regular election.

NOTE

*This amendment "except in the case of elected Trustees" is contingent upon the adoption of the proposed amendment to Article VI.

ARTICLE X—FUNDS AND EXPENSES

Section 1—Finances

Current expenses of this Society shall be met by an annual assessment upon each component society in the ratio of its membership, by donation, by sale of the Society's publications, and from miscellaneous revenues.

During the annual meeting, funds shall be appropriated by the House of Delegates for the budgeted items, but for no other purpose, unless authorized by a two-thirds vote of the members of the House of Delegates then present.

Section 2—Incurring Expense

The Board of Trustees may incur any necessary expenses between successive annual meetings.

ARTICLE XI—SEAL

The seal heretofore adopted and now in use shall continue, unless otherwise ordered by the House of Delegates, to be the Seal of The Medical Society of New Jersey.

ARTICLE XII—AMENDMENTS TO THE CONSTITUTION

This Constitution may be amended in the following manner:

A. Procedure for First Year

1. Submission of the proposed amendment in writing, through the secretary of this Society, to the Standing Committee on Revision of Constitution and Bylaws by the Board of Trustees, the Judicial Council, or a component society, at least three (3) months before the annual meeting.

2. Study of the proposed amendment by the Standing Committee on Revision of Constitution and Bylaws.

3. Submission of the proposed amendment in writing at the first session of the House of Delegates.

4. Report on the proposed amendment by the Standing Committee on Revision of Constitution and Bylaws at the first session of the House of Delegates.

(Proposed—continued)

5. Referral of the proposed amendment and report thereon to the appropriate reference committee.

6. Hearings on the proposed amendment and report thereon by the reference committee.

7. Report of the reference committee to the final session of the House of Delegates for appropriate action.

8. Acceptance by a majority vote of the members of the House of Delegates present at the final session.

B. Procedure for Second Year

9. Transmittal of the accepted amendment to each component society and publication in The Journal, at least three (3) months prior to the next annual meeting.

10. Adoption by a two-thirds vote of the members of the House of Delegates present at the final session.

MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY

(Reference Committee "C")
Board of Governors, Newark

Physicians' Medicare Claims

The experience in regard to the number of physicians' medical claims received by Medical Service Administration of New Jersey since the implementation of the Medicare Program on December 7, 1956, through April 19, 1957, is outlined as follows:

Total Number of Claims Received		1,800
Total Number of Claims Processed		1,464
For Payment		
(Claim Value $57,588.25)	698	
Declined	49	
Returned to Physicians for Additional Information	717	
On Hand, as of April 19, 1957, In Course of Process		336

The average current weekly receipt approximates 200 claims from physicians.

RESOLUTIONS

INDEMNITY BASIS FOR MEDICAL-SURGICAL PLAN

(Reference Committee "C")
From the Union County Medical Society

Because of the general dissatisfaction with injustices and inequities of the Medical-Surgical Plan of New Jersey and misunderstandings created in the minds of the patients and the physicians, the members of the Union County Medical Society voted on March 13, 1957, a resolution on this matter.

It is felt that an indemnity plan especially protecting the low income group as originally considered and instigated by the Medical-Surgical Plan of New Jersey would maintain a better relationship between groups of physicians, and particularly between physicians and patients. Such a plan may even increase the enrollment of physicians in it and be a more practical approach to the problem.

Whereas, the Medical-Surgical Plan of New Jersey was originally set up to take care of the low-waged and medically indigent groups on a minimum fee schedule on an inclusive fee basis; and,

Whereas, the Plan has long ago departed from this principle and is selling this contract to a very large percentage of the entire population of the state, thereby fixing service benefits to physicians in the Plan regardless of the amount of service rendered by the physician; and,

Whereas, the present minimum fee schedule for the poor is fast becoming the maximum fee for the entire population and a standard by which other fee schedules are being set up; therefore be it

Resolved, that the Medical-Surgical Plan of New Jersey be placed on an indemnity basis under the present laws if legally possible. If it is not legally possible, The Medical Society of New Jersey and the Medical-Surgical Plan of New Jersey be instructed to work to have the laws of the State of New Jersey changed so that our Medical-Surgical Plan may be set up on an indemnity basis as soon as possible.

MEDICAL-SURGICAL PLAN CONTRACT INEQUITIES

(Reference Committee "C")
From the Middlesex County Medical Society

Whereas, the individual members of The Medical Society of New Jersey have a vital interest in the actual contracts of the Medical-Surgical Plan of New Jersey; and

Whereas, the provisions of the Contracts of the Medical-Surgical Plan of New Jersey exhibit several inequities working to the detriment of both participating physician and the patient; therefore be it

Resolved, that the Middlesex County Component Medical Society demands that the following policy changes be effected by the Medical-Surgical Plan of New Jersey:

1. When the patient has multiple medical-surgical type coverage, either through non-profit or indemnity plans or both, the participating physician shall be entitled to his usual fee or to the value of the total medical-surgical type coverage, whichever is less;

2. Multiple non-profit medical-surgical type coverage, other than duplicate contracts within the same state, shall be allowed;

3. In third party actions the participating physician shall not have his fee restricted by the Medical - Surgical Plan of New Jersey, but shall be entitled to his usual fee or to the combined value of the fee paid by the Medical-Surgical Plan of New Jersey plus any judgment for medical services awarded the patient, whichever is less;

4. When necessary operative and non-operative care is rendered by one or more participating physicians, said operation either incidental to or secondary to the total non-operative care of the patient; the physician or physicians rendering the care shall be entitled to receive both the medical and surgical fees authorized under the schedule of payments of the Medical-Surgical Plan of New Jersey; and be it further

Resolved, that the Middlesex County Component Medical Society requests that consideration be given by the Medical-Surgical Plan of New Jersey to an increase in its schedule of fees and particularly to an increase in its variety of coverage, similar to that presently in force in neighboring states, where patients in much lower income groups are entitled to a greater variety and degree of coverage.

PROFESSIONAL LIABILITY INSURANCE

(Reference Committee "D")

From the Hudson County Medical Society

Whereas, there continue to arise within the membership of the Society, problems of diverse nature concerning professional liability insurance—not the least of which involve excessive cost of coverage, particularly in instances wherein a claim against the physician is on record; therefore be it

Resolved, that The Medical Society of New Jersey be requested to investigate the plight of those members who—having been involved in litigation with reference to professional liability—thereafter find it impossible to obtain proper coverage except at excessively high rates.

CLASSIFIED TELEPHONE DIRECTORY LISTINGS

(Reference Committee "E")

From the Bergen County Medical Society

Whereas, the New Jersey Bell Telephone Company now lists in its Classified Directory throughout the state under the title of "Physicians and Surgeons—Doctors of Medicine," anyone who claims to be one, and

Whereas, it is known that a substantial number of individuals not licensed to practice as Doctors of Medicine take advantage of this, and

Whereas, these same individuals frequently do not list themselves in their proper classification, and

Whereas, the New Jersey Bell Telephone Company feels it cannot insist on credentials from all who wish to be listed as Doctors of Medicine, therefore be it

Resolved, that The Medical Society of New Jersey negotiate with the New Jersey Bell Telephone Company and urge the company to do as is done in other states, and change its classified titles, statewide as follows:

First: "Physicians and Surgeons
Doctors of Medicine,
Members of X . . . . . County Medical Society
and/or: The Medical Society of New Jersey"
and
Second: (just plain) "Physicians and Surgeons—Doctors of Medicine," for those who do not qualify for the first listing.

CRIPPLED CHILDREN

(Reference Committee "E")

From the Passaic County Medical Society

Whereas, it is in the best interests of the people of New Jersey as well as the nation to assist our disabled handicapped children to assume their rightful place in society, and

Whereas, it is the considered opinion of this Body that this is hampered in part by:

a. Insufficient appropriation by the State
b. Laws which are out of date
c. Lack of provisions for many auxiliary services essential for rehabilitation

Whereas, it is felt that other neighboring states are rendering a more comprehensive service to their disabled children,

Whereas, a more realistic approach to the cost of hospitalization is needed,

Whereas, the scope of this program is beyond the level of service and fraternal organizations, and

Whereas, a full investigation and evaluation of this problem by our elected representa-

tives or other persons of integrity seems desirable, be it

Resolved, that The Passaic County Medical Society endorse these propositions and submit them to the House of The Medical Society of New Jersey for further endorsement and implementation.

ENGLISH AS A FACTOR FOR MEDICAL LICENSURE

(Reference Committee "E")

From the Bergen County Medical Society

Whereas, there is a growing number of foreign born and foreign trained physicians applying for medical license in the State of New Jersey, and

Whereas, easy and facile communication with the patient in a language understandable to him is an essential in practicing medicine, and

Whereas, postgraduate training, literature, hospital staff, medical society meetings, and medical convention, in this country are conducted in our local language, and

Whereas, The Medical Society of New Jersey and its component county societies are considered by the public to be responsible for the caliber and conduct of medical practitioners, both in professional matters and in their impact on the public, and

Whereas, it is well known that in spite of conducting the State Board examinations in English, a considerable number of applicants have been licensed who are deficient in ability to speak it well, and cause problems of communication with their colleagues, and what is even worse from a public relations standpoint, cause problems with the public, and

Whereas, it is obviously impossible to improve the absorption of postgraduate training in individuals who cannot comprehend because of language difficulties, and

Whereas, the local language in New Jersey is English; therefore be it

Resolved, that The Medical Society of New Jersey immediately urge upon its legislators to include in the statutes pertaining to licensing of practitioners of medicine, a clear, concise and inescapable device to insure the easy, facile, understandable use of the English language, both spoken and written, by every applicant before granting the license.

NURSING ASSISTANTS

(Reference Committee "E")

From the Union County Medical Society

Whereas, the medical profession has recognized a critical shortage of adequate nursing care in hospitals;

Whereas, the Union County Medical Society has initiated studies and investigations and met with favorable response from authorities and councilors in the secondary school system;

Whereas, these investigations and contacts have indicated that there are many deserving individuals interested in the care of the sick;

Whereas, the present requirements for graduate nurses are beyond the reach of the average individual;

Whereas, contacts with the authorities of the secondary school systems indicate a willingness and a desire in establishing training courses on the basis of a contracted period of training leading to a classified certificate under the existing laws; therefore be it

Resolved, 1. That The Medical Society of New Jersey look favorably upon such a program and that a Special Committee be appointed from the members of The Medical Society of New Jersey by the Board of Trustees to confer with the State Department of Education to explore the possibilities for the establishment of such courses and programs;

2. That the Department of Education be encouraged to foster such courses leading to the training of adequate nursing assistants with a proper degree of recognition;

3. That these individuals be licensed under the existing laws or, if that is not possible, changing of the existing laws be accomplished to enable these qualified graduates to engage in practice of their profession to the advantage of all.

BOARD OF OPHTHALMIC SURGERY

(Reference Committee "E")

From the Mercer County Medical Society

Whereas, we, the members of the Mercer County Component Medical Society, apprised of the change contemplated by the American Board of Ophthalmology to establish a Board of Ophthalmic Surgery, wish to present to the House of Delegates of The Medical Society of New Jersey, the following resolutions:

Whereas, it is the fundamental responsibility of the American Board of Ophthalmology in certifying candidates to guarantee to the public that the certified ophthalmologist is qualified in all phases of ophthalmology and is competent to assume his responsibilities in that branch of medicine in his community,

Whereas, it is the intent of the American Board of Ophthalmology to establish a certification in ophthalmic surgery, now therefore be it

Resolved, that it is our considered judgment that surgical certification apart from certification in ophthalmology has not been demonstrated to be in the interest of the public or the profession, be it further

Resolved, that no new Board of Ophthalmic Surgery within the American Board of Ophthalmology be established, be it further

Resolved, that this resolution be presented to the American Medical Association for appropriate action.

MEDICAL-SURGICAL PLAN FORUM

Saturday Evening, April 27, 1957

The Open Discussion on the Medical-Surgical Plan was convened at 8:10 p.m., Dr. Royal A. Schaaf presiding.

President Fritts: Ladies and Gentlemen: A few years ago we instituted this seminar to raise questions about Medical-Surgical Plan. This is open season. You all have your hunting licenses with you, I'm sure. You are privileged to clear up anything that has occurred to you about the Medical-Surgical Plan. Dr. Schaaf and his group will be here to answer all of your questions.

Dr. Royal A. Schaaf: Thank you very much, Dr. Fritts.

Good evening, ladies and gentlemen. Before beginning to talk about the Medical Service Administration and the Medical-Surgical Plan, I would like to introduce some of the personnel, officers and co-workers of the Plan. First, let me present Mr. Albert J. Durgom, who is Executive Vice-President of the Hospital Service Plan of New Jersey, to whom we are greatly indebted, particularly in the matter of sales. He has done a tremendous job of salesmanship and a good deal of the rapidly increasing enrollment of the Plan is the result of Mr. Durgom's skill and dexterity in securing group after group. He has really made a tremendous contribution to us and I take this opportunity personally to thank him for his contribution. I wonder if Mr. Durgom will take a bow. (Applause)

The other gentleman who is not a member of our staff is our counsel and very able adviser from the standpoint of law. He is Mr. William R. Vanderbilt, son of Chief Justice Vanderbilt. It is my privilege and pleasure to present him as our counsel. Mr. Vanderbilt, will you take a bow? (Applause)

Here is my old friend and colleague and your Vice-President of Blue Shield, Dr. Harry Comando, who has worked long and hard in the development of the Plan. He is a tower of strength to me and the members of the Board in the conduct of our activities. Dr. Comando. (Applause)

Next is Dr. Irving P. Borsher, who until last month was the Medical Director of the Medical-Surgical Plan. He has done yeoman service in the conduct of the Plan and much of its success is the result of the tremendous effort he put into our work. He is an expert in chest diseases, and after seven years as Medical Director, asked to be relieved in order to resume private practice. He will stay with the Plan on a part-time basis, as he was originally up until Dr. Scott's death, and I would like to record our appreciation of the time, effort and devotion which he has devoted to the activities of the Plan. Dr. Borsher. (Applause)

Next is Dr. Nicholas Alfano, who has succeeded Dr. Borsher as Medical Director. He has been Associate Medical Director for six years and is now Director. He is very skilled in the activities of the Plan and will contribute much to its further development. Dr. Alfano. (Applause)

Dr. Costello has been a Vice-President of the Plan for a great many years and he, too, has contributed much to our thinking and much to our progress, and it is a pleasure to acknowledge his contribution to our work. (Applause)

We have Dr. Carl Nacca, who is Assistant Medical Director, and he has been doing fine work. Dr. Nacca. (Applause)

And last but by no means least is Dr. Rothgesser, who is also an Assistant Medical Director. He does most of his work with the underwriting of group applications both for the Hospital Plan and for the Medical-Surgical Plan. Dr. Rothgesser, will you take a bow, please? (Applause)

Now, Dr. Dodd, won't you rise? (Applause) For many years, Dr. Dodd was active on our Board of Trustees. He recently was so overburdened by other activities that he had to ask to be released from the Board. But his services to us have been too valuable for us to let him get away entirely. He is now an adviser to our Board and he attends meetings and is altogether an astonishing fellow.

Here's another man you ought to know: Dr. Schretzmann. (Applause) And Dr. Keating of Passaic County. There he is. (Applause) And Dr. Sprague. He really deserves a long eulogy for his original conception of what became the Medical-Surgical Plan of New Jersey and for his early contribution to its organization and its plan.

Our organization consists of two parts. The Board of Trustees is not exactly an overlapping group, although the eight members of the Medical Service Administration are also members of the Board of Trustees of the Medical-Surgical Plan. They are actually two different organizations, although the Medical-Surgical Plan stemmed originally as an outgrowth from the Medical Service Administration.

The Medical Service Administration is now in its seventeenth year of operation, having begun in April 1941. It is devoted principally at present to the distribution of medical care to indigent and medically indigent persons and certain other activities. It is the one non-governmental agency in the state chartered to handle funds from government sources for payment of any type of medical care rendered to wards of the state, county or municipality. The federal government may also utilize our services and they have done so in the "Medicare" program.

Originally the Medical Service Administration planned a program of pre-payment sickness insurance We had a wonderful contract. It was good, but it was too expensive and we never sold it after a year of activity. So we then broke away and developed the Medical-Surgical Plan which is strictly an insurance organization.

At the outset we handled the business of the farm medical care program. In the early forties that was suspended when the need for it disappeared. Also, we launched the "home town medical care" project for the Veterans Administration and conducted that for a while in 1947. Then we turned it back to the government quite gladly. At present, the activities are two: one is work for the City of Newark in the matter of indigent and medically indigent care; and we are the fiscal agent of The Medical Society of New Jersey in the conduct of "Medicare." We have subcontracted our appointment by the government as fiscal agent to the Hospital Service Plan of New Jersey and they actually do the technical part of the work of "Medicare." However, the legal responsibility for it lies in the Medical Service Administration. The government will not pay what they consider to be any part of two payments for the same service. However, we have a very amicable agreement and I think it is working satisfactorily.

You have seen the report of the Medical Service Administration in the April JOURNAL and that brings you up to date with the exception of the item relating to "Medicare:" that is, the number of claims and the amount of money expended in the program since its inception on December 7, 1956.

The total number of claims received since December 7th was 1800; the total number of claims processed were 1464; for payment, 698; for a total sum of $57,588.25. Forty-nine claims were declined; 717 were returned for additional information. As of April 19, there were still 336 claims awaiting process. At the present time the average current weekly receipt approximates 200 claims from physicians.

Demands for this service are not nearly as great as the government originally contemplated they would be. They are more nearly what the Board of Medical Service Administration computed their probable incidence. We are really not very far off in the matter of our own estimate of claimants, which is smaller than the government's estimate.

This is a very satisfactory program. The schedule of benefits for physicians' fees was arrived at by negotiation between a special committee of The Medical Society of New Jersey and the Department of the Army and it is a very adequate schedule of benefits in view of the salary range of the beneficiaries.

We offered, as the Medical Service Administration, also to conduct the business of the New Jersey Hospital Association. They preferred, however, to negotiate a direct arrangement with the Hospital Service Plan of New Jersey, who were also processing the claims for hospital benefits.

I think the Medical Service Administration has demonstrated its usefulness to the people of New Jersey. It has certainly fulfilled the purpose for which it was established and, in the judgment of our Board, its continuance is really an urgently vital matter. The Medical Society of New Jersey must have an agency which can deal with questions of indigent and medically indigent care or other types of governmental service which are not on an insurance basis. The Medical-Surgical Plan Board declined an offer of the government to utilize our resources. We felt that if we were operating two schedules of benefits it would lead to endless confusion in the minds of our participating physicians were it handled by the same organization. So the Board of the Medical-Surgical Plan graciously declined the offer to conduct the work and it is still being done in the Medical Service Administration.

Maintenance of the Medical Service Administration in the last few years has been to a considerable extent dependent upon the generosity of The Medical Society of New Jersey. Our income from the indigent care in Newark, for which we get ten per cent of the gross payments, is not adequate properly to pay our salaried administrative secretary and the other expenses of the office. For the last three years we have come to the Society and asked for a subsidy in the amount of $5,000, which has been granted.

We would not be calling on the Society for support were it not for the fact that the indigent load is happily so very low now. I think

it is the lowest it has been in the history of Newark since we have been participating in the plan. Since our income depends on the case load, it is a happy thing we don't have enough money from the city to pay our expenses because it reflects a degree of prosperity for which we all should be grateful.

This $5,000 item is in the budget for next year. While we may not need it, I would like to have it a matter of record that our Board does feel that this is a vitally urgent organization which should be maintained at least in mothball status. This agency has made a tremendous contribution in that it developed the original Medical-Surgical Plan. Every investment which was made in that Plan has paid tremendous rewards both to the people of the state and to the profession. So I would like to enter an earnest plea again for endorsement of the continuance of the $5,000 grant if we find next January that it is necessary

Now we come to the subject of the Medical-Surgical Plan. Our report is in the JOURNAL and you have copies of it. We are now ending our fifteenth full year of operation. In the past year our enrollment increased 146,000 to a total enrollment of 1,546,000. Payments to physicians in 1956 were $18,435,000, for a total in 15 years of $82,384,000-plus. In 1956 our earned income was $22,400,000, of which 84½ cents per dollar were incurred for claims, 9.7 cents operating expenses, and 5.8 cents added to our reserves. Our reserves now are roughly $7,500,000, which is enough to enable us to operate for four months were we to get no income. To be a stable plan it is estimated that we should have a minimum of four months, and we just about make that.

At no time has the integrity of the funds of the Plan been seriously endangered. In 1952 when we had a slump in enrollment we had to reduce certain payments. They were all subsequently restored and additions were made to it. So that the Plan is on an absolutely sound financial basis.

I would like at this point to mention the contribution of our three lay advisers. Mr. John S. Thompson has been with the Board since the beginning. It was his computation which put the Plan on a sound actuarial and financial basis from which it has never been dislodged. Then we have Mr. Carl Withers, an expert banker. He is now President of Blue Cross and he has been of enormous help to us in the matter of investment of our reserves. And then we have Mr. Lumm, formerly General Manager of the General Electric Company in the Newark area and a man of wide business experience. He is President of the Board of Trustees of the Presbyterian Hospital and he has a wide knowledge of prepaid sickness and hospital insurance. Those three men have made a great contribution.

Our doctors have all worked tremendously well and long. I have never been associated with a group who have been as earnest and as conscientious and as self-sacrificing in service as they have been. They come to every meeting. Our new counsel was astonished when he saw that we had about ninety per cent attendance at all of our Board meetings. Sometimes we have a hundred per cent — not quite always, but almost always. It is really an amazing thing. It is a tribute to the men who have given so much time and effort to it.

Now, the striking thing which has occurred in the past year was the distribution of the 1956 contract in May of that year. While we will not be completely converted for two more months, we are pretty close to complete conversion from the 1949 to the 1956 contract.

At previous meetings of the House of Delegates, our Board was requested to make certain contract changes. We have made every change which was practicable. There were a few over which we had no control because of the ruling or the attitude of the Department of Banking and Insurance. They required certain procedures and would not agree to our elimination of those points in our program. That Department exercises so much greater control over Blue Shield and Blue Cross than they do over commercial insurance companies. Being a non-profit organization, we are tax-exempt and for that reason the Banking Department feels that it has even a greater obligation to protect the interests of the public than they would in commercial programs. That is why we occasionally have had difficulties with the Banking Department when we wanted to do something which they said we could not do.

But consider what we *have* done. We have increased medical benefits. We made eligible for payment outpatient surgical services done in hospital departments. We consider that a very great expansion of benefits. Incidentally, it relieves the stress on the hospitals in the matter of admissions for minor cases. They can be done in the out-patient departments. It frees the bed. And, since all of these people have Blue Cross—it cuts down on the demands against the Blue Cross Plan.

Surgical services out of the hospital were increased to $50 instead of $25 and eligible for accidental injury provided service begins within 48 hours of the accident. New-born in-

fants are eligible from the date of birth rather than from the seventh day as formerly. Consultations are payable only once, but it is an eligible service beyond that payment because it is not covered by the contract. A consultant can bill for additional consultation, which he could not do formerly.

The altered income level is not as drastic as it seems because it is limited to the multiple person contract. The individual level remains at $5,000. We have increased the schedule of benefits, not quite as much as we would like but about as much as the premium rate will stand and as much as we can sell at that level.

With a great deal of difficulty we accomplished something which we had been urged to do for a number of years and that was to pay participating physicians directly and to pay the subscriber in instances where the eligible service was rendered by a non-participating physician who was eligible to be, but was not, a participant. It was the feeling of this House of Delegates many times, and vigorously expressed, that some recognition should be made of the physicians who contributed to the service benefit features of the program, and in this manner we have accomplished that directive.

There have been substantial changes in the schedule of benefits. For instance we have gone on "the $300 schedule;" that is, the maximum payment made for an operation in any one of the fields—general surgery or lung surgery or brain surgery or orthopedic surgery — is $300 instead of $250. We restored all the cuts which were made in 1952, so that we now have a very liberal schedule of benefits.

New York and Pennsylvania have two levels of contract, which we were unable to attain because of disapproval by our State Banking Department. Certain benefits are higher in the New York schedule or the Pennsylvania schedule than they are in ours. But when this complaint is made, the fact is overlooked that the number of payments in the higher schedule is relatively small, whereas the payment in the lower schedule is much greater. So that the combined average of those two is generally lower than our schedule of payments for the same service, and they give it across the board.

We tried to develop two levels of payment with two premium rates and two schedules of benefits. The Banking Department said that we could not justify a different charge for the same service. So we had to abandon the idea of a double level contract, and the logic—I don't want to go into it at the moment, but the logic is perfectly good; it is cogent reasoning, and we had to accept it.

Our schedule *on the average* is better than the New York schedule or the Pennsylvania schedule. As a matter of fact, I think that with a few minor items or a few occasional items it is the highest schedule of benefits in the United States.

Mr. Durgom, is that true?

MR. DURGOM: That is correct.

DR. SCHAAF: Thank you. Mr. Durgom knows everything about every other plan in the United States, and when I want a little point of information of that type I am very glad to have him around as my mentor.

Probably the most spectacular change which has occurred in the past year has been the offering of the group enrollment program supplementing our standard contract. That is being offered currently and we are about to embark on a statewide campaign for a limited time. Reason for the limitation is to prevent undue selection against a company. If we ran it continuously, people who expected to use it—they use the facilities of both Blue Cross and Blue Shield, incidentally, this will be a joint campaign—there would be a tremendous number of people who would come in because they expected to use it. The only way we can protect ourselves against that selection against us is to make a limited, broad-based offering and then close it out. Wait six months perhaps, and come back again. But if they dribble in and out, the selection will be inevitably against us. This is a giant step forward. In fact our great weakness in dealing with the question of distribution of medical care lay in the fact that we were unable, until recently, to offer a direct enrollment contract. The enrollment in the Hospital Plan at this time is just about two million. The enrollment in our plans is just under 1,600,000. The difference is largely in the number of direct enrollees which the Hospital Plan has had for some years and whom we are just about to try to bring into our coverage.

There have been repeated urgings on the part of various specialty groups, particularly those in radiology, to bring the services of those specialties into our contract. We are about to offer to the Banking Department a proposal to provide these additional benefits under a rider. We have finally gotten agreement, in principle, to let us use riders, but the Banking Department wants to scrutinize very carefully what we propose to do with them. That will enable us to do several things. It will satisfy the legitimate demands of certain large groups of special practitioners and

it will also enable us to offer a contract which will be acceptable. It is an amazing contract. We think we have the best contract in the United States and if we add the supplemental advantages on a rider basis we think we would be pretty well out in the lead.

We are now integrating our claim service. Part of our claim processing was conducted by the staff of the Hospital Service Plan and part of it was conducted by our medical staff with claim examiners. Within the next few weeks, maybe the next few months, there will be complete integration of the medical claim units of the Hospital Plan and our own medical claim unit. That will expedite the conduct of our business in all the state. It will be much more economical because a much smaller number of employees will handle a little larger business. It will augment the efficiency very much and we are pleased to have it develop in this manner.

For some years we were in the Kinney Building. On February 4, 1957, we began conducting our business in our new quarters known as the Blue Cross-Blue Shield Building at 500 Broad Street, Newark. The building is ultra-modern, with air conditioning, automatic elevators and all modern architectural features. We hope that all of you who have an interest in this work will come to our offices and see what we have. We are very proud of them and we think that we are headed to great things.

At this point I would like to listen to questions.

DR. EDWARD G. GULLORD (Essex): What has been done with the resolution of last year regarding medical fees? We, in internal medicine, feel that we are inadequately paid, and I'd like to know what has been done regarding that resolution of last year.

DR. SCHAAF: The committee has considered it, not only this year but previous years. We have not abandoned the idea of trying to develop a package for medical fees which will be patterned after what is, in effect, a package method for paying of surgical and other fees. It is a difficult thing and it involves something over which we have no control. It actually involves the Plan being required to differentiate between qualities of medical service.

If you will stop and think of the surgical fees, whether a neophyte does an appendectomy or the most skillful of our surgeons does the appendectomy the fee is the same. What the medical specialists, certified board diplomates particularly, are asking us to do is to put a different valuation on the services of a specialist as compared to a general practitioner. That is not something that our Board is able to do. I'm certain that you couldn't sell the idea to the Department of Banking and Insurance. To them a medical call made by me (and I am not a certified medical specialist) is just as valuable as a medical call made by a specialist; and the Plan simply can't differentiate between the qualities of medical services. That is the great stumbling block.

The only way it can be done is to develop in the minds of the public the idea that medical services are just as valuable as surgical services. A man whose life is saved by a physician when he has coronary trouble has had just as great a service as the man whose life is saved, who had a perforated ulcer that a surgeon operated on. But our Board is unable to differentiate between quality of medical service, and if I can get that one point over it will explain why we are having difficulty.

We explored the possibility of developing a package method of payment for different categories of illness. The categories became so enormous we just couldn't deal with them. But fundamentally the difficulty lies in our inability as a Board legally to differentiate between qualities of medical service. We just can't do it and it's an almost impossible thing.

DR. GULLORD: I'd like to suggest to you, if possible, to differentiate between serious medical illness and non-serious medical illness by virtue of using a consultant.

DR. SCHAAF: We do. There is available in the new contract a $35 additional benefit for extra medical care which is given in the first forty-eight hours.

DR. GULLORD: How about using a consultant as an individual who can certify this case to the Medical-Surgical Board as a serious illness, and going on from there?

DR. SCHAAF: Well, that would certainly be impossible, Doctor. For instance, you would then have to say, well, this is a serious appendicitis or this is a serious perforated ulcer.

DR. GULLORD: We don't care about surgery. We are talking about medicine.

DR. SCHAAF: You've got to apply the same principle in the whole category. You cannot differentiate between degrees of medical service or qualities of medical service because the Banking Department doesn't recognize it.

DR. GULLORD: I don't care about the Banking Department. We are talking about people and patients.

DR. SCHAAF: We do, because we do business with the Banking Department. And if we offered a program which they wouldn't accept, you might just as well not offer it.

DR. GULLORD: I'm not offering anything that they wouldn't accept necessarily. You could certify a medical illness in the same way that you say an appendectomy is worth $150, or whatever the Plan says. If a consultant says that that medical illness is a serious medical illness it seems to me it puts it in an entirely different category than the ordinary garden variety of medical illnesses that come under the Surgical Plan. That means you could differentiate these things into serious medical illness, which is what we are complaining about, and ordinary medical illness which is perfectly satisfactory in terms of compensation from the Medical-Surgical Plan.

DR. SCHAAF: All I can say about it is that an enormous amount of time and thought has been devoted to this and it is considered utterly impractical to differentiate between degrees of illness or the quality of medical care. We can't do that.

DR. GULLORD: You can't do that, but a consultant can, Doctor.

DR. SCHAAF: Anybody can be a consultant. Years ago we seriously undertook to develop a method of payment for consulting service based on qualifications. We tried desperately, repeatedly, urgently, to get from The Medical Society of New Jersey some criterion of specialist, and they wouldn't furnish us with any.

You see, there is only one criterion of medical care legally, and that is a license to practice medicine in the state. If I say I'm a specialist in heart disease, legally I'm a specialist in heart disease, you see.

DR. GULLORD: Nevertheless, Doctor, if some consultant categorizes an illness as severe and as requiring a different category of payment, you have two people then that have categorized that thing and you are immediately eliminating a large number of illnesses which would otherwise perhaps be brought to the attention of the Medical-Surgical Plan. In other words, it would be actuarially sound if you had two people to certify it rather than one.

DR. SCHAAF: Well, it wouldn't be actuarially sound. Show me a single instance where it has been done.

DR. GULLORD: Well, I don't know. I'm asking that it be considered.

DR. SCHAAF: After all, Doctor, you are asking us to do something, and the Board has spent many years and tremendous time and effort on the problem and by the best standards it is impracticable. The only way it could be done would be if The Medical Society of New Jersey said these people are specialists. If Dr. Comando was not included as a specialist in the treatment of penumonia, he could go to the Banking Department and say: what right has this organization to say that I am not competent as a specialist? It just isn't practicable. It is a good theory, but it just won't work.

DR. GULLORD: I'd like to see it tried.

DR. SCHAAF: Well, you can't try something which is impractical and which the Banking Department won't let you try. Blue Shield all over the country has experimented enormously and many times their experiments have been tremendously successful. But oftentimes it is not a success. Then, of course, it costs the plan money. But you show us how to do it and we will be very glad to try it.

DR. IRVING LERMAN (Union): You say fees have been increased to $300. The last I had contact with the Plan there hadn't been an increase.

DR. SCHAAF: It's in the contract since May 1, 1956. What item are you referring to?

DR. LERMAN: Prostatectomy is still only $250.

DR. SCHAAF: I didn't say all the schedules had; I said quite generally they had been. The top surgical fee is now $300.

DR. LERMAN: I'd like to answer the question that arose about consultants. I know it is a difficult problem, but a few hospitals are beginning to classify consultants. I know Beth Israel in Newark has and the General Hospital in Elizabeth has now classified the doctors who are eligible to be consultants on hospital patients. One cannot simply call anybody as a consultant. He must have been classified by the hospital.

DR. SCHAAF: That is perfectly true of individual hospitals, but this Board would have to have an equally applicable criterion by which to judge specialists. As you know, the Office of Veterans Affairs have had four or five criteria which might make a doctor eligible for a specialist's fee, but The Medical Society of New Jersey wouldn't authorize us to do that. It was suggested that we develop our own schedule of consultants. We would be hopelessly ruined if we tried to do it. We would have a suit on our hands immediately.

DR. E. H. POGUE (Union): Dr. Schaaf, in the new contract we are limited to one consultation during a particular hospital stay. Yet in many cases, more than one consultation, not necessarily with the same consultant, is both necessary and desirable, the way we are required to practice. Could you tell me why the consultations have been limited to one?

DR. SCHAAF: If one consultation has been

held and another is necessary, either with the same physician or another physician, the consultant can send a bill for that consultation. Under the service benefit program he is permitted only one consultation if it is paid to him. We had difficulty adequately compensating specialists. It was suggested that we eliminate consultations completely from the contract, which would then give a participating physician who was a specialist in certain circumstances the opportunity to send an additional bill for that service because it wasn't eligible as part of the contract. Again we strove mightily to get it out of the contract, but the Banking Department wouldn't let us do it because in their opinion it represented a diminution of benefits. They would not approve a contract which made any essential change particularly in the matter of diminution of benefits, and that would have been one. So we had to keep one in to get by the Banking Department. But he is eligible now for an additional consultation by the same physician or by other physicians if it is an additional one. So it is a better method than the other. It is not perfect, but it is still a better method.

Incidentally, Dr. Gullord, that might be the answer to your problem. You are not restricted in your charges.

DR. GEORGE HELLER (Bergen): Suppose a patient has multiple insurance policies where the service charge allowed is less than the customary fee for that service but the person is covered by other policies. Is it permissible for him to ask for a greater fee than is being granted by our Plan?

DR. SCHAAF: If he is a participating physician, it is not. The reason for that is this: that the payments under the sickness and accident insurance, whether it is for medical care or hospital care or loss of income or whatever, are not income, and that is the ruling of the Commissioner of Internal Revenue. So that unless the patient's or the subscriber's family income is over $7,500 you are bound by that because that is not income. Multiple coverage might arise if an individual has been very prudent and affluent and has provided himself with more than one policy. If he has, quite generally his income is above $7,500. In other instances the double coverage originates because the husband is working in one plant and the wife in another and they thus have double coverage, one in Blue Cross or Blue Shield and one in, we'll say, the Travelers Insurance Company. But in those instances under present conditions the combined income of subscriber and spouse almost inevitably exceeds $7,500, so that you do not have the imposition on the physician or surgeon that we used to have when the income of the subscriber alone prevailed.

DR. HELLER: Is there any liaison between our own group and the New York Medical Service?—their "United Medical Service?"

DR. SCHAAF: Not directly, only through the Blue Shield Medical Care Plans, Incorporated, which includes all other plans.

DR. HELLER: I am told that if a New Jersey physician has a patient who works in New York, they say payment has been made to the patient. Is there any redress we have through our own Society or must we deal directly with them?

DR. SCHAAF: You have to deal with their medical service. We have no official connection with them, except we are both Blue Shield Plans. That is a totally separate business. If the difficulty is there, it would have to be handled directly with the UMS; with us, if there is a complaint against the Plan, it can be taken to the advisory committees of the county society. Our position is that we never argue with a doctor and we refer the matter to an advisory committee of the county society, and almost invariably redress will be obtained. Justice is on the side of the doctor. The Plan has had relatively few such situations, but when an advisory committee has asked us to do something or suggested that in their judgment our position was wrong, we are very happy to take their advice. We can do it within the statute.

DR. ROBERT E. VERDON (Bergen): What has happened to the apportionment of surgical fees which was endorsed last year?

DR. SCHAAF: It is available and I can't tell you exactly the number of times that we have been requested to do it. It is much smaller than we thought it might be, much smaller.

DR. VERDON: Some doctors say that they have applied for it, it's been put in, but they have never gotten it. What reason could there be that they could not have gotten it?

DR. SCHAAF: It depends how they put it in. You will notice that there is a little box there, about the middle of the sheet, which says if apportionment of available benefits is to be made, request for special form should be made to the Medical-Surgical Plan office. In other words, we don't distribute those forms generally as we do the ordinary blank.

DR. VERDON: Is that the same as the brown form for special service?

DR. SCHAAF: No. That is special services. The apportionment is on the original blue

form and it has to be signed by the operating surgeon.

The data here indicate that out of 5,000 surgical cases, apportionment of available benefits was requested in 15. It is a small number, much smaller than we thought it would be.

DR. VERDON: It was asked in 15. How many were paid?

DR. SCHAAF: Dr. Alfano tells me that all of them were paid.

DR. VERDON: Is there any contract in effect in which these apportionment rules would not apply?

DR. SCHAAF: Yes. There are a few 1949 contracts. I think perhaps 10 per cent of our contracts are still in 1949. It would take a few months before they are eliminated. This apportionment is not available on anything except the 1956 contract.

DR. FINE (Mercer): I'd like to know why the Blue Shield refuses to pay for electroconvulsive therapy in the treatment of mental cases.

DR. ALFANO: We do not pay for it, *per se*. It is paid on a medical care basis.

DR. FINE: Why the discrimination against the psychiatrist for the care of mental cases?

DR. ALFANO: There is no discrimination there. It was an item that was not included in the general schedule of payments. Every new item to be introduced in the schedule of payments must be reviewed by our fee committee. We have had no complaints by any psychiatrist as to the non-payment for electric shock therapy. It has not been presented to our fee committee.

DR. VERDON: Did you say that the Banking Commissioner now allows you to have riders on the contract?

DR. SCHAAF: I said that they had agreed "in principle" to consider a rider. Up until a few weeks ago they were adamant about riders. They would not tolerate them. But we have gotten to the point now where they are willing to consider a proposal for a rider provided we send the appropriate data. Their objection to riders was that we had no sound actuarial information on which we could base a rate computation. We have tried to get data on the subject from all over the country and we think that we can come up very soon with a projected rate and I succeeded in getting their consent. I say I succeeded, because it was an individual, no one else was there but myself. I got their consent finally.

DR. VERDON: The point I was getting at with the rider, if the Plan depends upon participating physicians for its success why then can't doctors who wish to belong to the Plan belong without being held to certain percentages? Why can't the man belong on a group subscription rate without having to get sixty or seventy per cent of the membership?

DR. SCHAAF: Well, you have to go back now to the inception of the enabling act. Two provisions were included in the enabling act to satisfy the Department of Banking and Insurance that it would be equitable to the subscribers; to assure that there would be enough physicians to render this service to afford the subscriber a reasonably broad choice of physicians.

Then the enabling act says that the prepayment non-profit sickness insurance program may be set up if its board of trustees is composed of officers who have been endorsed by a society of two thousand members. Thus, in effect any non-profit sickness insurance corporation must have, under the present statute, the endorsement of The Medical Society of New Jersey; that is its practical effect, and that is why you can't do it, because to operate a service benefit program and to be tax exempt the state owes it to the public to make certain that a reasonably good cross-section of the profession will be available. The minimum number was 51 per cent. That's on a county basis under the law.

DR. SMITH: If any one county went below 51 per cent would the Plan go out?

DR. SCHAAF: No, but the Plan couldn't do business in that county.

DR. VERDON: Why couldn't the doctors as a group be covered by the Medical-Surgical Plan?

DR. SCHAAF: They could be. We can cover 51 per cent as a group, and this coverage will be available under this individual offering which we are going to make in May and June. But the county society would have to give us 51 per cent in order to give us a proper spread of risk. We would have a tremendous selection. We don't take any group with less than 50 per cent anywhere because the selection becomes too great against you, and some of our groups go as high as 90 per cent. For instance, in a group of school teachers we require 90 per cent. The reason for that is not because they get sick oftener but when they do get sick they go to hospitals and they all stay 14 days. Many of them are single women living in boarding houses or small apartments and when they get sick there is no one to take care of them but the hospitals.

There is only one group of people who are worse risks than teachers in hospitalization and in medical care and that is the ordinary worker in the hospital. I don't mean the nurses'

staff or the administrative staff, but rather the kitchen help, scrub-women and so on. Most of them live either in boarding houses or rooming houses, though some hospitals actually have accommodation for them. When they get sick they have to be hospitalized and their incidence of illness is terrific because so many of them are handicapped people.

In the Massachusettes General Hospital they have what they call a group of 400 ground-men. Among them, there is not a single able-bodied man; every one is handicapped, some with one arm, one eye, one foot, might have a hernia—they've got something which makes them not good employees in those fields, but they are perfectly good and they are earning a living at work which they can do, but they are very bad risks for that.

DR. MILLER (Monmouth): What is the maximum that the Plan will pay for a hospital coronary patient hospitalized for 21 days?

DR. SCHAAF: It's $145 to one physician, plus one consultation fee above that.

DR. MILLER: It's not worth as much as a peptic ulcer, then, or any surgical procedure.

DR. SCHAAF: That is not the decision of the Board of Trustees of the Medical-Surgical Plan. That's the present medical practice. It's nothing we have anything to do with. We are operating within the existing pattern of medical practice.

DR. MILLER: When is something going to be done to correct this inequity?

DR. SCHAAF: When the medical physician is recognized as just as valuable as the surgeon. That is an emotional concept that our Board had nothing to do with. The surgeon has always had a psychological advantage in the mind of the public over the medical man, but that's nothing that we had anything to do with, and our Board recognized the immense value of medical service comparable to surgical service. In our minds there is no difference, but in the minds of the public there is a tremendous difference.

DR. EDMUND E. JACOBITTI (Bergen): The Blue Cross and Blue Shield continue to limit the age of dependency to 19. The New York plan has increased it for doctors' dependent children to 21. Medicare has increased it to 21, and the income tax people have increased it to 21. Why can't Blue Cross and Blue Shield increase it?

DR. SCHAAF: I will ask Mr. Durgom to answer that; he is an expert on it. It is a matter of the Hospital Plan more than the Medical Plan.

MR. DURGOM: The age limit with regard to dependent children of a family, such as 19 to which you referred as being the limit in New Jersey, is one of the subscription rate calculations. If the Plan were to extend the age limit to 21, it would mean additional exposure on the Plan to a broader area of risk because there would be children covered under family contracts for two more years. That would be a matter to be placed under advisement by the two plans and a coordination of thinking with regard to the actuarial end of the business. I wouldn't want to make a statement to the effect that the Plan will never do it. I have never heard that the Plan had stated that they wouldn't do it, but it isn't possible under the present subscription rate.

DR. MILLER: Why are elective surgical procedures not eligible if performed outside of the hospital?

DR. SCHAAF: To cover them outside the hospital, you'd have to have a very substantial increase in your premium rate. You just cannot do it within the present premium rate. If the premium rate gets beyond a certain figure, you can't sell it. It's better to give a little less coverage and keep more people in the Plan that it is to give so much coverage to a few that you price yourself out of the market.

DR. MILLER: I don't understand why you would have to increase. Say that somebody comes into my office with an ingrown toenail. This toenail's got to be removed. What's the difference if it's done in a hospital or it's done in a doctor's office? Actually it's going to wind up costing your combined people less money if it is done in the doctor's office.

DR. SCHAAF: Statistically it will increase the rate very materially. Mr. Durgom can give you more details on that aspect of it. We computed surgery in office, and it will make a very substantial difference in the premium rate.

DR. MILLER: Has it been tried?

DR. SCHAAF: Doctor, you don't want to forget something. We are not trying to cover and we shouldn't try to cover every type of service. We are designed to cover catastrophic illness. You know, we would never take out fire insurance if we thought we were never going to have a fire that would cost us more than $25. There is an element of co-insurance that all of these plans must have effective and the worker must be willing to take care of an occasional office or house call.

DR. MILLER: You do insure minor illnesses. I'm not talking about a three or a five-dollar office call; I'm talking about minor surgical procedures as office procedures.

DR. SCHAAF: May I change that and say minor medical or surgical expenses.

DR. MILLER: All right. If a toenail is removed in a hospital, what do you allow for it?

DR. SCHAAF: $25. But it has to be done in a hospital.

DR. MILLER: All right. Why is it not eligible if done in a doctor's office?

DR. SCHAAF: It doesn't come within our definition of catastrophic illness.

DR. MILLER: But it does if it is done in a hospital.

DR. SCHAAF: Well, anything that requires a hospital admission or surgical treatment in the out-patient department comes in the broad category of catastrophic illness.

DR. MILLER: Then I put it to you that this is not a catastrophic illness and it ought to be dropped from the Plan.

DR. SCHAAF: Not necessarily. If it is done in the hospital, it shouldn't be. After all, you have to have a definition of an area in which you are trying to work.

DR. POGUE: Dr. Schaaf, I think the point is well taken. Many procedures take place in our Elizabeth hospitals, which could be done *outside* of the hospital and which the Medical-Surgical Plan pays for because the patients are in-patients. They tie up beds which the Hospital Service Plan has to pay for and in which fees are paid for anesthesia. A great deal of that expense could be eliminated if these procedures would be done in a surgeon's office; because, as Dr. Miller says, when a toenail has to come off, it's going to come off and then Blue Cross has to pay for one or two or three or four or five hospital days.

DR. SCHAAF: You are now asking why doctors impose on Blue Cross and Blue Shield. It's what is going to ruin Blue Cross and Blue Shield if the doctors don't conscientiously work within the terms of the contract.

DR. POGUE: Doctor, I'm not asking that as a question; I'm stating that as a fact. That happens.

DR. SCHAAF: That's what I'm saying. You are admitting that in your hospital they are doing it.

DR. MILLER: Do you suggest that a doctor is imposing on the Medical-Surgical Plan when he hospitalizes a patient for a procedure when that patient has hospitalization and medical-surgical insurance for which he has paid?

DR. SCHAAF: If it is not in the premium rate, he hasn't paid for it.

DR. MILLER: I'm saying that he is covered under the Plan. And I want to add to that one other thing, too. You talk about catastrophic illness. I know that the United Medical Service pays for catastrophic illness, in the nature of a three-dollar office call and in the nature of a five-dollar house call because I've gotten reimbursed by this plan for catastrophic illness.

DR. SCHAAF: They don't have the same definition of catastrophic illness as we do. They have a great variety of contracts and there is no one of them which is equal to our single contract, no one of their contracts.

The moderator then called for further questions. As there were none, Dr. Schaaf continued:

DR. SCHAAF: Thank you very much. It has been a pleasure to have been with you. Good evening to you all!

(Applause. The meeting concluded at 9:30 p.m.)

BESTOWAL OF GOLDEN MERIT AWARDS

Sunday Afternoon, April 28, 1957

The Officers, Fellows, Delegates, Members and guests met at Haddon Hall at 2:30 p.m. to witness the bestowal of the Golden Merit Award to 119 members each of whom had honorably and devotedly completed fifty years of practice. Dr. Samuel M. Diskan, chairman of the subcommittee on public relations presented the recipients, with each county president serving as Assistant Grand Marshal.

PRESIDENT FRITTS: Ladies and Gentlemen. In the 191 years which have passed since The Medical Society of New Jersey was founded, 163 presidents before me have performed innumerable duties, acquitted themselves of unnumbered responsibilities, and enjoyed uncounted privileges. Today, however, I am given a duty, responsibility, and privilege which no one of them ever enjoyed, and which no president who succeeds me can ever claim. Mine is the unique honor to preside at the first bestowal of the Golden Merit Award, established this year by The Medical Society of New Jersey as an expression of its pride in, and affectionate regard for those of its members who have completed half a hundred years in the practice of medicine.

The fifty years just passed have truly been a golden age of progress and accomplishment in the area of scientific medical and surgical treatment. The man who entered practice fifty years ago in his own life span has witnessed the invention and utilization of scientific discoveries and technics that have swung wide the portals of hope for the afflicted.

Diseases and conditions—almost too numerous to detail — which at the beginning of such a man's professional career would have defied the power of the doctor now prove readily responsive to methods of treatment which have been made widely available. The workers in the vineyard of Medicine during the last fifty years have toiled with such magnificent effect as to win the admiration and gratefulness of the entire world, and to make all men and women their debtors.

Therefore, my beloved and venerable colleagues, it is not merely for the long years of your service that we acclaim you here today. It is especially because by your industry and your diligent scientific endeavors you have enriched the world and have given to your fellowmen the priceless gifts of sounder health and longer life.

You are among the most illustrious of living men and women, as you are among the most generous and the most deserving. Each of you has made of his life a gift of significant service, and in consequence you are enshrined in the minds and hearts of all those who truly appreciate the worth and greatness of your giving. You are the pride of Medicine. You are the benefactors of mankind.

I count it, therefore, one of the highest privileges of my life, as President of The Medical Society of New Jersey, to say to you, in the name of the people of New Jersey, in the name of the profession of Medicine, in the name of all mankind, "We thank you!"

The Award is conferred upon the following, listed alphabetically by counties:

ATLANTIC COUNTY

William W. Fox
Benjamin L. Gordon
Samuel L. Salasin

BERGEN COUNTY

Geoffrey C. H. Burns
Charles D. Cropsey
William Fessler
Samuel T. Hubbard
Winfield S. Kilts
Harriet L. Knox
James M. Mac Kellar
Charles A. Richardson
Frances B. Tyson
Joseph S. Van Dyke
William L. Vroom
William C. Williams

BURLINGTON COUNTY

Jacob M. Davis
Emma W. Metzer
George T. Tracy

CAMDEN COUNTY

Charles F. Hadley
Earl S. Hallinger
Ernest G. Hummel
Charles H. Jackson

CUMBERLAND COUNTY

George A. Davies
Charles M. Gray
Alfred G. Sheppard
John H. Winslow

ESSEX COUNTY

William H. Areson
Angelo R. Bianchi
Stella S. Bradford
Hermann Cohn
Richard H. Dieffenbach
Harry B. Epstein
D. Webb Granberry
Bernard H. Greenfield
Albert S. Harden
E. Zeh Hawkes
G. Rae Lewis
James H. Lowrey
Federico Luongo
Lodovico Mancusi-Ungaro
Dennis F. O'Connor
Michael J. O'Connor
William Petry
Erwin Reissman
Louis H. Robinson
Elbert S. Sherman
Edward W. Sprague
Alfred Stahl
Erwin Steiner
Harold A. Tarbell
Charles E. Teeter
Adelbert B. Twitchell
Arthur Weller
Bernhardt H. Woolf

GLOUCESTER COUNTY

J. Harris Underwood

HUDSON COUNTY

Arthur F. Ash
Mary B. Carr
Ellis J. Chapman
Warren J. Duckett
Charles H. Finke
Frederick A. Finn
Karl H. Goldstone
J. Eugenia Jacques
Thomas D. Keegan
Jacob L. Mathesheimer
Christian H. Mershcimer
William J. Meyer
George W. Muttart
Frederick S. Pindar
Jacob L. Rosenstein
Emilie V. Rundlett
David L. Russell
Nathaniel J. Shapiro
N. A. Vostrosablin

HUNTERDON COUNTY

George Henry

MERCER COUNTY

David B. Ackley
Enoch Blackwell
William J. Harman
A. Dunbar Hutchinson
Ellen C. Potter
George N. J. Sommer
Irvine F. P. Turner
Charles H. Waters

MIDDLESEX COUNTY

Norman N. Forney
Charles L. Naulty, Jr.
Laurance P. Runyon
Charles I. Silk
Charles H. Smith

MONMOUTH COUNTY

Harry W. Ingling
Harry B. Slocum
Julius A. Toren
Robert B. Wilson

MORRIS COUNTY

Aldo B. Coultas

OCEAN COUNTY

Frank Lehmacher

PASSAIC COUNTY

David J. Carlough
David R. Crounse
Owsley B. Duncan
Morris S. Joelson
Lester F. Meloney
Charles R. Mitchell
Charles J. Murn
Joseph H. Oram
Jacob Roemer
William P. Thorne
Andrew W. Vanderbeek
G. J. Van Schoot, Jr.
Hiram Williams

SALEM COUNTY

Warren L. Ewen
William T. Hilliard
C. Percy Lummis
Claude W. Thomas

SOMERSET COUNTY

Frank L. Field
Edgar T. Flint

UNION COUNTY

Charles T. Decker
Frederick W. Sell
Milton A. Shangle
Emil Stein
Rolland D. Tomlinson

WARREN COUNTY

Edgar N. Brasefield
Frank S. Gordon

GENERAL SESSION

Monday Evening, April 29, 1957

The General Session was convened at 8:05 p.m.

PRESIDENT FRITTS: Good evening, Ladies and Gentlemen, and welcome to our General Session. It will be conducted this evening in two parts. The first and the most wonderful part of the program for me is to introduce to you my friend and colleague, Dr. Albert Kump, the new President of The Medical Society of New Jersey, who will give to us his inaugural address. (Applause)

DR. ALBERT B. KUMP: Mr. President, Distinguished and Welcome Guests, Fellow Members of The Medical Society of New Jersey, Ladies and Gentlemen:

Even as I enter upon the presentation of this inaugural address, it is still to me a matter of surprise—amounting almost to disbelief — to realize that by your generous choice I am the one hundred and sixty-fifth President of The Medical Society of New Jersey.

It is likewise a matter almost of awe to me to recognize the great trust and weighty responsibilities that thus you lay upon me. No less am I impressed by the realization that it becomes now my part to carry on in conformity with the splendid example and tradition of the leaders of medicine in New Jersey who have preceded me in this high office.

I accept the honor that you do me with a grateful and humble heart. I pledge you my devotion and my service. I shall do all in my power to keep faith with the best of the past and, at the same time, to be alive and responsive to the demands of the present and the challenges of the future.

I know that I shall not labor alone in the effort to protect and advance the medical interests of the people and of my colleagues of New Jersey. For one hundred and ninety-one years cooperation has been the secret of medicine's progress in New Jersey. I count upon the continuance and growth of that cooperation—for the good name of the Society we constitute, and for the welfare of the people we serve.

Between the time of the establishment of The Medical Society of New Jersey in 1766 and the present, almost incredible progress has been made in the science and art of medicine. In no other department of human endeavor can we find such consistent progress, such constant and admirable elevation of methods and standards of service and achievement as are found in the sphere of medical and surgical practice.

The proof of this is seen in the long list of diseases which once, unimpeded, freely ravaged men of their very lives, but which now, in our day, like captured beasts, are mastered and controlled by intelligent and intrepid science wielding the whip of knowledge.

In this regard we live and practice in circumstances immensely and essentially different from, and superior to, those which confronted our medical ancestors. But in one circumstance our situation is not far removed from theirs. In their day they were called upon to fight for freedom, so that they and their fellow Americans did not live in the restrictive shadows of a social system that would deprive them of initiative and of the privilege of free practice and untrammeled action.

The fight for freedom continues, even today. It has changed only in incidentals; in essentials it remains the same. In their day our forefathers strove to wrest their freedom from an alien government which, in opposition to the will of the citizenry, sought to usurp the rights of the individual for the exaltation of the power of the few who typified the state.

In our day, as citizens we are called upon to preserve our freedom against a threat which arises not out of the selfishness of an alien government but out of our own selfish shortsightedness. Strong with the might of our universal suffrage, we incline sometimes to exercise our sovereign powers unwisely for ourselves.

Freedom and justice must go hand in hand for the maintenance of the balance which makes for peace and happiness. If freedom is coupled with injustice, the inevitable result is conflict and discord.

This is a truth which we, and all Americans, must recognize and respect, or else be prepared to lose the goal which as a people we have ever pursued.

An accurate concept of freedom is vital for its survival in a democracy. Properly considered, freedom is an inspiration to and a guarantee of achievement, order and peace. Improperly considered it can lead to anguish, anarchy, and chaos.

Freedom may be defined as the privilege and the capacity by means of which individuals and peoples may live their lives without undue or undesirable constraints. True freedom is not characterized by the absence of all restraints or restrictions. Such a state is abandonment rather than freedom. True freedom necessitates regard for the fundamental rights of others, and respect for the due and desirable constraints of just and proper laws, whether those laws be of God, of nature, or of men.

This is the concept of freedom which is essential to the preservation of order and peace and happiness. This is the concept which must prevail unless we—mistaking license for liberty, abandonment for freedom—are to sink by progressive stages from indiscipline to degradation and from degradation to basest slavery. He is most basely enslaved who is a slave to self.

The human agent who properly exercises freedom is not free to do whatever he wants to do, but free to do whatever he sees he ought to do. Such a one is restricted in the scope of his actions by the limitations of justice and propriety, by a stern regard for basic rights, of self or others, and by a respect for the reciprocal duties which those rights involve.

In all his uncompelled actions, the free man is

governed by the constructive disciplines of standards of judgment that have full regard for the rightness and desirability—from all points of view—of the actions which he places. He is a free agent because he is a responsible agent. Otherwise he would be either the slave of others who assume responsibility for him, or the slave of his own irrepressible instincts and urgings.

President Eisenhower sounded a note of warning for us all in his State of the Union Address. He declared: "Freedom has been defined as the opportunity for self-discipline. Should we persistently fail to discipline ourselves, eventually there will be increasing pressure on government to redress the failure. By that process freedom will step by step disappear . . ."

The other side of the coin of freedom is responsibility. Possessing that coin of freedom, we possess, or should possess, in equal measure the coin of responsibility. Let us of The Medical Society of New Jersey cherish them both equally and together. Thus we will well acquit ourselves as members of a great and honorable profession and as citizens of a great and growing nation. Living thus, we will serve ourselves well; and by the example and inspiration of our lives, we will serve equally well our fellow citizens and our country.

(Applause)

PRESIDENT FRITTS: Thank you, Dr. Kump, for this inspiring message.

The rest of the program I will turn over to Dr. Daniel Featherston, who will be your Master of Ceremonies from this point on. Thank you.

DR. DANIEL F. FEATHERSTON: Mr. President, Ladies and Gentlemen: I don't think any meeting of The Medical Society of New Jersey should begin without recognition of the fact that New Jersey has been granted the highest honor that it is within the power of doctors to bestow. While a man should never be introduced in his own home town, David Allman should never be in a room with a group of doctors without being introduced, and I hope at this time he will say a few words to us. Dr. Allman. (Applause)

DR. DAVID B. ALLMAN: Thank you very much, Dr. Featherston.

For the benefit of those of you who were here this afternoon and heard me present our new President to the House of Delegates, after having heard his Presidential address you know what I'm talking about. The Medical Society of New Jersey is indeed in good hands for the coming year and, as I said in closing, we have another good President.

Congratulations, Al.

I'm happy to be here tonight. I am glad to have some little part in this forum on medical-legal testimony that is about to take place. For some reason I have become rather interested in the association of the American Bar Association and the American Medical Association.

The film which you are about to witness now, entitled *The Medical Witness,* was premiered in November, in Seattle, at our annual session and at that time the President of the American Bar Association, Mr. David Maxwell, and I had the pleasure of introducing that film.

Now, it's nice that we get together here, a few lawyers and we doctors to go over certain problems that are of mutual interest. For a long time I have maintained that American medicine should become closer allied with such distinguished groups as the American Bar, the American Dental Association, and other allied groups because socio-economic things being the way they are now and with what is happening to segments of medicine because of bureaucratic administration in Washington, makes us firmly know that we need allies and we need allies of the type of men of the American Bar. And I'm happy particularly, having had some association with the Legislative Committee of the American Medical Association, as you well know, and trying for three years to get some form of legislation through similar to the Jenkins-Keogh Bill — it was first the Read-Jenkins, then the Read-Keogh, now the Jenkins-Keogh Bill — we were unsuccessful, but now the American Bar Association has taken up the cudgels and they are working very hard, and I think at the present time the bill has the best chance it has ever had of passing. As near as I can find out, the chances are a little better than fifty-fifty, which is better than we of medicine alone could do.

But the Bar Association has now become interested, and if we did nothing else, we at least woke the American Bar up to the fact that they are vitally interested in that legislation because what affects us today will affect them tomorrow and there is no question about it that it is coming, and unless we stand united we are going to fall singly. So, as I say, I'm very happy.

Then there are other fields that we and the American Bar on the local level, state or county level, can work together. On the problem of drug addiction, we are working together. In the field of drunken driving we are doing a lot together. And there are many other facets of medicine and law that are so entwined that it is to our reciprocal advantage to have a better understanding of each other and to work in closer cooperation. And therefore, I'm happy to participate in any small way in any gathering where these two grand professions are united for a common purpose.

I'm sure you are going to enjoy this forum tonight. I won't take any more of your time I know from the legal standpoint that you will be pleased with the presentation of Judge Proctor and my good friend, the President of the Atlantic County Bar Association, Herbert Horn; and certainly we have with us tonight our especially talented Moderator, Dan Featherston; and Henry Davidson who, you know, is never at a loss for words; and in the place of Asher Yaguda you are going to hear from Dr. Kaufman. I'm sure that you will enjoy the evening.

I'm happy to be here and have some small part in it. I thank you, Dr. Featherston, for giving me this opportunity to say a few words.

DR. FEATHERSTON: Thank you very much. (Applause)

Ladies and Gentlemen: The program is completely unrehearsed. It will be played by ear all the way through. The gentlemen that Dr. Allman has mentioned to you have not prepared any script.

We hope that following the presentation of the film, which will be the next thing on the program, that questions will be offered the Panel. And I hope the questions will be sufficiently provocative that they will not agree among themselves on them. If they do, I'm sure that they will provoke a discussion and offer you some material for thought on something that the doctors are becoming more interested in. There is hardly a doctor who, during the course of the year, does not have some reason to go to court. Unfortunately, most doctors don't like it. There are others who rather thrive on it. Some place between the two extremes is probably the right way to do it.

We hope that with the picture and with a sufficient discussion tonight we can provoke for you and for the benefit of the doctors what we think is the right way to present the subject that we have undertaken.

(The film, "The Medical Witness," was then projected on the screen.)

DR. FEATHERSTON: I would like to introduce the gentlemen here with us and ask them to say a few words of introduction on the subject, which I hope will provoke questions from the floor.

Mr. Herbert Horn is the President of the Atlantic County Bar Association and I am informed that he is an excellent defense lawyer. I wonder what his opinion would be and what his advice would be to the doctor as a defense witness.

MR. HERBERT HORN: Well, Dr. Featherston, this catches me a little unawares. I was originally asked to talk about the medical witness from the plaintiff's point of view. I thought I was particularly qualified because I try ten times more defense cases than plaintiffs' cases.

But I don't think there is much difference between the doctor testifying for the defense and the doctor testifying for the plaintiff. The doctor is supposed to be, and I can say truly in most cases, is an impartial witness from the standpoint of trying to establish the truth of his own convictions.

This picture that we have seen speaks much more eloquently than I could possibly speak on the subject. It shows that just being a physician is not really enough to make a good witness. Note that in this film the first doctor was not prepared. He had talked to the lawyer in advance and, as has been told, there is absolutely nothing wrong with that. It was put in a bad light because, as demonstrated, the doctor was flustered—I think that was the word used.

But he must bone up on the subject. If he's got a conviction as to his opinion, that conviction must be demonstrated in the best light. He should be prepared to support it by facts that lead to the support of that opinion. The doctor at all times must remember that he is in the court to do justice just as much, really, as the judge, the jury and the lawyers.

In the film the lawyer was a little better prepared, too, when the second doctor was presented. At least he had his hypothetical question written out and could present all of the facts to the doctor so the doctor could intelligently give a bona fide and proper answer.

So I say, Dr. Featherston, that in the final analysis there isn't too much difference between testifying for a plaintiff or testifying for a defendant, and the whole thing is to present your case, both from the doctor's standpoint as well as from the lawyer's standpoint, in the light of trying to get to the truth.

DR. FEATHERSTON: Thank you very much, Mr. Horn.

Judge Haydn Proctor is a Judge of the Superior Court of New Jersey. He lives in Asbury Park and is presently assigned to Hudson County.

I wonder what advice you would have to give to the doctor, Judge.

JUDGE HAYDN PROCTOR: Well, Dr. Featherston, I don't know what medical school this Dr. Phillips, the first doctor that testified for the plaintiff, went to, but I don't believe he ever graduated from any primary school of manners, the way he conducted himself.

I think the picture has a great message. Of

course, it is exaggerated, particularly the first part, but that is good propaganda and good reason to put its message over.

But, as Mr. Horn said—of course, the lawyer was the same character in the movie—but his demeanor completely changed. If you will notice, when the first witness was on, when the x-rays were shown, he stood directly in front of the jury and the jury never had a chance to look at the x-rays. And when he was the second lawyer, although he was the same lawyer, he had a shadow box there and he apparently had arranged to have that skeleton there.

But what struck me most in the whole picture is this—and I find it in my work—that many physicians in testifying use the patois, the jargon of the medical profession without realizing that the jury is made up of twelve people of only average intelligence, from all walks of life. And even in this picture, if you will notice, they mentioned the word "orthopedist" or "orthopedics," but no one explained to the jury just what "orthopedics" meant. Now, of course, doctors may say it is very foolish to say that, but I'm sure that the average juror doesn't know that. It should be explained right in the beginning just what "orthopedics" means. And all medical terms should be immediately translated into common, everyday language. And that is the most important message that this picture brought to me.

DR. FEATHERSTON: Thank you very much.

Dr. Kaufman doesn't look like Dr. Asher Yaguda, who was supposed to be here but he unfortunately didn't make the plane connection from Newark; so Jerry Kaufman, on very short notice, five minutes ago, said, "Yes, I'll be on the Panel."

Jerry, how do you like lawyers in court, especially on cross-examination? And I hope I'm not crossing Dr. Davidson up because I don't know what I asked him to say.

DR. JEROME G. KAUFMAN: Well, I don't believe that this picture showed the entire story. As Judge Proctor said, there are many things missing. You will note that this paragon of virtue, Dr. Childs, was not cross-examined in the picture. (Laughter) And you didn't see him get flustered. And I'm sure that the attorney who was so clever with the first witness, Dr. Phillips, could put the pressure on him. Even though he was so well prepared, Dr. Childs might find it a little difficult.

Then you will notice that the terminology with Dr. Childs was a little loose near the end —"Could be," "might be." I don't think in this state Judge Proctor would permit you to answer a question so loosely. Also, "reasonable certainty" was used there. In this state, for example, the term is "reasonable probability."

Many physicians are careless about records, careless in general. But at least in cases that are going to be litigated their records should be complete, concise and clear because either the attorney for the plaintiff or the defense has the opportunity of reading and examining your records. And, as the Judge says, it is important that in addressing the court and the jury the terminology be simple and that the answers be given, whenever possible, on a yes or no basis. Many times you are not permitted to qualify an answer, and many times you get into trouble when you speak beyond what you should say.

There are three phases of testimony. One is the legal phase, and with that we have very little to do. Then there is the medical phase, and that is what medicine teaches you about an accident or about a heart condition or about something else. And then finally there is the medico-legal phase and that is really the putting together of many pieces in a jigsaw so that you see a clear picture; and the answer to the hypothetical question as given to either doctor tonight is really that jigsaw puzzle put together. You have to answer the question not necessarily in legal terms, which isn't the business of the doctor, or in purely medical terms, but on a combination of the factors so that you can give to the court and jury a clear understanding of what the relationship of that particular accident was to this particular back injury.

When a doctor is subpoenaed, he must go to court. If the subpoena is given to him within close approximation of the time he has to appear in court, he should notify the attorney. If he doesn't get satisfaction, he communicates with the clerk of the court and explains the situation. He will probably then be given an opportunity of appearing at a later date, if that is possible. You must realize, however, that at times a jury has been sworn, the case has been going on for a few days, and it is necessary to terminate such a case. That is a question between both the lawyers and the doctors; and if the lawyer is courteous to the doctor and gives him a reasonable time, the doctor should be courteous and respond to that particular subpoena.

There are two kinds of witnesses. There is the factual witness—a man who is subpoenaed to bring to court his record to testify as to particular facts, a particular situation that he has treated the patient for. Then there is the

expert witness. He is a man who is hired at a particular fee to come into court and bring with him his expert technical knowledge on a particular specialty or a particular situation. He is a man who is on a voluntary basis. He is not subpoenaed. He is hired by the attorney for the plaintiff or the defense to appear in court to help win or lose this case. And that is a little different from the doctor who is subpoenaed. But once you are subpoenaed it is the courteous and ethical thing to respond to that subpoena within reasonable time.

DR. FEATHERSTON: Thank you very much, Dr. Kaufman.

No panel would be a success without a psychiatrist, and that is why we have asked Dr. Davidson, who I'm sure you all recognize as the Editor of our JOURNAL, to be here. I avoided getting surgeons on this Panel because I don't want them to talk about negligence, but I want him to talk about the technic of testimony.

DR. HENRY A. DAVIDSON: The Judge in this picture said that the first mistake that Dr. Phillips made was to treat the opposing attorney as an enemy. Well, I think we must not kid ourselves. The purpose of an advocate is to advocate. He is supposed to be one-sided. An attorney in the middle of a trial who could see both sides and balance them equally wouldn't stay in business very long. His purpose clearly is to win the case within the framework of the law.

Now, obviously if the medical witness gives testimony which is going to hurt him, the lawyer's business is either to discredit the medical witness or, to put it more charitably, to show that the witness's theory of the case could be wrong. But doctors are accustomed to having their word taken — such phrases as "Doctor's orders" and "Do what the doctor says" are part of our language. Doctors are not accustomed to being questioned and quizzed, particularly by non-doctors.

Consider the physician who is being cross-examined. He is faced by an attorney whose main purpose at the moment is either to discredit him or to show he is in error. The doctor is bound to feel that this man who is cross-examining him is hostile to him. It would scarcely be human nature for him to take any other view. Now, that doesn't mean, of course, that he should lose his temper, since this would lower his defens s. But at least it is somewhat fatuous to say: don't consider the attorney on the other side an adversary. If the doctor were not going to say things which the attorney on the other side didn't find acceptable, he wouldn't be on the stand at all.

One of the difficulties in communicating between our two professions is this: the law works on the theory that there is an absolute truth. If you add sodium chloride to silver nitrate you will get a precipitate of silver chloride. This is true. And if you swear otherwise, you are a perjuror because it's absolutely true. However, it is not absolutely true that a blow in the chest can cause or cannot cause an endocarditis, or that a blow on the back will or will not cause a slipped disc. These are not truths; these are opinions. And under the circumstances, the advice that all the doctor has to do is to testify as to the truth is perhaps a gospel of perfection. There are many truths. But now I see somebody who looks like a very distinguished visitor standing in the back of the hall. I seem to recognize him.

DR. FEATHERSTON: May I interrupt the Panel at this time? We see in the back of the hall that the Medical Society has been honored by the presence of a very distinguished visitor. I would like to introduce to you Governor Robert Meyner of New Jersey.

(The audience arose and applauded.)

GOVERNOR MEYNER: Mr. Chairman and Members of The Medical Society of New Jersey in convention assembled:

I should probably explain my presence here this evening. My own personal physician, Dr. Buchanan, called me this afternoon and said, "Won't you drop in at the medical convention?" And I said, "I have an invitation to attend an affair this evening and it was sent to me by your President." Apparently I am a Trustee of the State Bar Association and as such was invited to attend this affair. So I left the practical nurses and came over to meet with the doctors a moment. (Laughter)

Some one said the other day that I am now speaking with new zest after an event some three months ago. (Laughter)

A youngster was asked to write an essay about Benjamin Franklin. The essay read something like this: Benjamin Franklin was born in Boston. At an early age he went to work in his brother's print shop. He didn't get along with his brother. He quit. He decided to go to Philadelphia. He got off the boat in Philadelphia. He walked up Market Street and went into a bakery, bought some rolls, met a girl, married her, and discovered electricity. (Laughter and applause)

I want to commend your Medical Society for putting on the kind of Forum you have here tonight, because for years I engaged in the general practice of the law and I had an opportunity to know the variation in thinking which exists between lawyers and the medical

doctors. We are all interested in the same objective, I'm sure, and you are to be commended in trying to reach a point of working arrangements so that the objectives can be achieved and you don't get bogged down in semantics.

Congratulations on this fine program. It's nice to have said hello to you this evening.

(The audience arose and applauded.)

DR. FEATHERSTON: Judge Proctor, there has been an attempt — and it is working in New York—to establish a panel of medical expert witnesses for the courts, which would be court-appointed. What do you think of that as a principle?

JUDGE PROCTOR: Well, that has only recently been established in New York, and on that panel in New York the court, through the Ford Foundation, I believe, and the Sloan Foundation, has a fund which they used initially. As I understand it, a panel of doctors is drawn up. And if the judge sees that the doctors are far apart—the doctors for the plaintiff are on one side and the doctors for the defendant are on the other side, the judge can appoint one of the doctors from this panel. I understand that this program is fostered by the medical society and the lawyers went along with it. The impartial medical witness then makes a report, and most times the case is settled. But if it is not settled, then the judge can summon that witness to testify. That doesn't cost the litigants any money. It is paid for by the court, and I think in the long run it saves the court a lot of money because it dispenses with a lot of jury trials which, of course, are expensive.

You asked me what I think of it. I think favorably of it, but I certainly would want to hear some arguments on the other side before I made any definitive statement. It sounds very good to me. I don't know how it is working out in New York, but it sounds to me as if it is the coming thing, in view of the fact that the courts are really clogged with litigation and eighty per cent of all litigation is made up of personal injury accidents, and it would be one way of solving litigation and probably bring in a better result to litigants, too.

DR. FEATHERSTON: Thank you.

Dr. Kaufman, do you think that there are any defects in that system?

DR. KAUFMAN: The defect in it is: Is there such a thing as an impartial witness? A witness can have a viewpoint which would be plaintiff-minded or defendant-minded, but still be honest, because medicine is not a science; medicine is an art. Take, for example, the question of the relationship of coronary thrombosis to industry, which has today three schools of thought throughout the United States and Canada, and these three schools of thought are very wide apart.

If a judge in selecting from a panel would select a doctor who happenend to be of the school that was most liberal, such as perhaps Massachusetts courts have done, where any particular employee who develops, let's say, a coronary thrombosis is considered to have a compensable accident, then the judge would get an honest witness, but certainly he would not be impartial; it would be a viewpoint.

And I feel that unless one could have a panel of several men and each of these men could be cross-examined, that there would be a great danger in the use of a panel and for that reason I believe that in this State it has not been looked upon favorably.

DR. FEATHERSTON: Thank you very much.

Dr. Davidson, do you think it is ethical for a physician to appear as a witness in a case with the understanding that his fee for testifying will be contingent upon the outcome of the case?

DR. DAVIDSON: If by "contingent" you mean the larger the recovery, the larger the fee, no. If, however, by "contingent" you mean a situation where the plaintiff is presently indigent, he cannot pay the doctor, and if the doctor says: I'm so ethical I won't testify until I get cash on the line, so that the plaintiff can't get any witness at all, then the answer is it would be unethical for the physician to *refuse* to appear.

For example, a man is earning $30 a week and he's got a head injury; he is out of work; he has no income; and he sustained a concussion of the brain, a contusion of the brain, a fractured skull. He wants to get a doctor to testify and he has no money. And so they call in the doctor and he says, "Well, I won't testify unless you guarantee my fee." I can't guarantee you the fee." "No testimony." If all the doctors in town are that ethical, this indigent man goes without any doctor at all and he is forced to settle the case for whatever he can get.

The canons of ethics of the A.M.A. state that the indigent have a call on us for our services, and I therefore would say that the doctor should agree to testify in a case of that sort because that is the only way the man can get justice. Of course, if he recovers a $20,000 verdict, he is no longer indigent and he ought to pay his medical bills.

DR. KAUFMAN: I believe that it is the duty of every attending physician to testify for his

patient when that patient is a litigant in court, and I believe that under such circumstances he should charge a reasonable fee. And, although it isn't unethical to accept a fee on contingency, The Medical Society of New Jersey frowns upon it.

Dr. Featherston: Mr. Horn, what have you to say as to the fact that the contingency fee for a lawyer is perfectly ethical?

Mr. Horn: It's not perfectly ethical. For a long time it was criticized, as a matter of fact it wasn't ethical or considered legal up until about a hundred years ago. It was considered as fostering litigation. But today it is considered ethical and is permitted because it does aid the indigent to recover. Probably more people in these accident cases are represented by attorneys on a contingent fee basis than otherwise. But that has just grown by custom. There used to be a word for it. I think it was "champerty." That word has gone out.

Dr. Featherston: It would seem to a great many people that a fee for services would be a more equitable way of being paid for that type of case.

Judge Proctor: Of course, there is a differnce between a doctor and a lawyer. A lawyer is supposed to do his best for his client whether he is getting paid for it on a contingency basis or whether he is getting paid for it by the day; whereas, a doctor is merely testifying in court under oath. The lawyer isn't doing that.

Dr. Featherston: Let's go back to that. If a negligence case is brought to your ward service in the hospital, for instance, ordinarily you would have no fee. Now, it is litigated and they do collect a fee. In a case like that the doctor expects, of course, to be paid. Now, I can't see the difference.

Judge Proctor: He should be paid.

Dr. Featherston: I'm trying to get back to the percentage factor involved. Why, for instance, does an attorney take a fee of, perhaps 33 per cent of the negligence verdict?

Judge Proctor: That's the usual fee.

Dr. Featherston: Why is it not fair to the doctor to work on that basis, too? A doctor doesn't. His is strictly a fee for service.

Mr. Horn: Let me cite the closest thing I can recall to that. It has been the custom, as I understand it, among doctors not to charge each other; that is, a matter of courtesy, for their respective services. Some years ago, as I recall, there was a reported decision where a doctor's daughter was injured and another physician treated her. The case came into court and he testified.

The question was: "Do you have a charge?" And his answer was: "If there is a recovery here, I intend to charge so much. If there is no recovery, I do not intend to charge anything." And, as the court said, that was perfectly all right and recovery was permitted.

That is the closest thing that I know to it. And I don't know that it is unethical for such a thing as that, as long as it is out in the open so that at least the jury who is going to decide the case can take that into consideration as to affecting the credibility of the physician.

Dr. Featherston: Judge Proctor, some one wants to know: Do you think that a six-man jury would relieve the backlog of cases that are now awaiting trial?

Judge Proctor: Not in any significant amount. It would just mean that it would take a little less time to draw a six-man jury. But the drawing of a jury doesn't take very long.

Of course, we couldn't have a six-man jury unless the people consented to it because under the Constitution you are entitled to a twelve-man jury. So without the consent of the litigants you can't have a six man jury except in a case under fifty dollars.

Mr. Horn: Dr. Featherston, I'd like to call the attention of the assembly here to an article written by one of the members of this Panel, which I have read, and I felt it very good; as a matter of fact, it was so good that it was published in one magazine, then picked up and published in another. I have seen it in both. It is entitled "The Care and Feeding of The Medical Witness," a very good article by Dr. Henry A. Davidson. And incidentally, in that he tells you what he thinks about the matter of having impartial medical witnesses.

Dr. Featherston: He and I don't agree on that. (Laughter)

Someone in the room says: There are rumors that they are going to abolish the hypothetical question.

Mr. Horn: Well, I personally have heard no such rumors, but I'll tell you in the practice of law, as in the practice of medicine, we learn things as we go along. The hypothetical question today is used, but I think that now we've gotten to the point where we are gradually getting away from it. It doesn't mean anything except it takes a lot of time. There are some cases where it is important, but I think that in most cases that I have been trying and I've seen other lawyers try, and I'm sure I think that Judge Proctor will tell you that they will waive the hypothetical and let the doctor go ahead and testify in his opinion

there is a relationship between the so-called accident and the trauma.

DR. FEATHERSTON: In that moving picture was the only hypothetical question that I ever heard presented that wasn't objected to.

JUDGE PROCTOR: In ninety-nine cases out of a hundred there is no hypothetical question anymore.

DR. FEATHERSTON: Someone wants to know: Is it unwise from a medical witness point of view to consent to an offer to waive stating the doctor's qualifications?

JUDGE PROCTOR: Well, the doctor's qualifications usually are waived by the defendant when the plaintiff's doctor is on. I know if I were representing the plaintiff I would want to qualify my doctor, even if the defendant says, "I'll waive the qualifications." I'd want my doctor to testify to all of the degrees and whatever he has done because it is very impressive to the jury. And you will find most lawyers when they put a doctor on the stand, even though the other side waives the qualifications, you will find that he usually puts in all the qualifications, and I think it is very good psychology. I don't know how Mr. Horn feels about that.

MR. HORN: It depends on the case, as far as we are concerned. If it is a case where it could help, naturally we want the jury to know the qualifications. On the other hand, if it is a petty case, it will take time, we waive them.

DR. FEATHERSTON: These questions are running about the same, but they are all legal questions. Here's one.

Is it unethical for a lawyer to ask a physician to slant his testimony? (Laughter)

MR. HORN: That's the same kind of question, Dr. Featherston, where a man was looking at a motor boat at the show and he asked the price of it. The salesman said, "If you have to ask the price, you cannot be interested in the first place." (Laughter)

DR. FEATHERSTON: Do lawyers want or permit a testifying physician to be unbiased or impartial?

MR. HORN: Well, I can't speak for the others or some of the others. I feel that it is up to each man. As far as I'm concerned, I think the answer is obvious. But in case it isn't. I don't think that he should be biased.

DR. DAVIDSON: Wait a minute. You wouldn't put a doctor on the stand whose testimony was going to destroy your case.

MR. HORN: No.

DR. DAVIDSON: In that case you will put on the stand only a doctor whose testimony will help your case.

MR. HORN: Yes, but that doesn't mean bias. That means giving his own honest opinion as to the case. (Laughter)

DR. FEATHERSTON: He wants to be awful sure of what the doctor is going to say. (Laughter)

Some one wants to know: Is it ethical for a physician to sit in the box with a lawyer and prompt him concerning questions to ask another doctor testifying?

DR. KAUFMAN: There is nothing unethical about it, but certainly it is not good practice and bad taste. I don't think the Medical Society would countenance it very much, certainly should frown upon it.

DR. FEATHERSTON: It's a good way to lose a friend.

DR. DAVIDSON: In this connection, John Hoffinger, in the June 1950 Yale Law Journal, discussing the psychopath as a witness, suggests that the psychiatrist could sit at the counsel table and tell the lawyer what questions to ask this witness in cross-examination. The idea would be to bring out to the jury the fact that the witness is untrustworthy. Hoffinger explains in this article why he makes such a suggestion, taking cognizance of the fact that, as Dr. Kaufman has said, it is considered bad tactics because it makes the doctor look like a branch of the lawyer's office. But the point he makes is that the jury is always drawing conclusions about a witness's credibility anyway and why not therefore have an expert, a psychiatrist who is an expert in uncovering the kind of motivation behind people, function as an arm of the attorney's office for this rather special purpose. And this is the only time I have seen that point of view openly defended in a legal publication.

DR. FEATHERSTON: One of the best things to do on cross-examination, if you have an opportunity, is to put some humor into the answer.

DR. KAUFMAN: That always riles the counsel, who gets a little mad, just like the doctor did tonight in the picture, and helps you with the jury, I'm quite sure.

DR. FEATHERSTON: Is the doctor entitled to a fee if he is subpoenaed not as an expert witness?

JUDGE PROCTOR: No, he is not if he is not subpoenaed as an expert witness. Well, of course, every witness is entitled to, I think it is, fifty cents or a dollar. But if he is not subpoenaed as an expert witness, he would be in the same position as any other witness.

Supposing a doctor saw an automobile accident. He wouldn't be paid any more than any other witness. But for testifying as an expert, he is entitled to a fee in every case.

DR. KAUFMAN: Does a doctor have to become an expert witness to appear?

DR. FEATHERSTON: It's my understanding that a doctor, because of having his doctorate, is an expert in the field. There is no question about qualifications as an expert.

MR. HORN: That's true, and what that means is this: you may have a man who, let's say, is licensed to practice medicine in this state, who is qualified, or he has studied orthopedics and is a diplomate and all the rest of it, he can testify as to x-rays, he can testify as to eyes, he can testify to any other part without having had any special qualifications other than his license to practice medicine.

DR. FEATHERSTON: Here is one I don't quite understand. Maybe whoever wrote it will clarify it.

"Are there different standards of medical testimony in (1) criminal actions such as murder; (2) drunken driving; (3) Compensation claims; and (4) negligence or liability?"

I don't know what the "different standards" mean.

MR. HORN: Well, there is a different standard in law, Dr. Featherston. For example, in a criminal case you've got to prove beyond reasonable doubt; in a civil case, by preponderance of the evidence. Now, perhaps that is akin to that.

The answer is no, there isn't. A man is either drunk or he isn't drunk; that's all there is to it.

DR. FEATHERSTON: Dr. Kaufman has a question here that he doesn't understand.

"You spoke earlier about a subpoenaed doctor. Tell why it is better physician public relations to pay him a fair fee. When is a subpoena justified?"

He passes that one.

JUDGE PROCTOR: Well, a subpoena is justified—I don't like to see laywers subpoena doctors because a doctor as a rule testifies as an expert. I think the lawyer should consult with the doctor and arrange with the physician to see that the doctor's time is husbanded so the physician won't waste any time in the court house. And I can see an extreme case where the doctor says, "I absolutely won't come to court; I just won't come." Well then, of course, I suppose in a case like that the lawyer would be forced to subpoena him, but that is a most unusual case.

DR. FEATHERSTON: Do you think Dr. Davidson, that the average family physician is competent to determine the percentage of permanent disability?

DR. DAVIDSON: The fact that the questioner uses the term "percentage" would indicate that he is talking about Workmen's Compensation, since in the ordinary automobile accident or negligence case that term is not used. In Workmen's Compensation cases the answer to that is "no," because there has developed over the years in the Compensation Law a kind of understanding as to what is meant by these various percentages which sometimes bears very little resemblance to reality. Thus a concept in the Workmen's Compensation Bureau of ten per cent disability is something which most of the experts in the field come to agree on. In fact, it would be very proper cross-examination if a family doctor, who had very little experience, said, "I think this man is thirty-three and a third per cent disabled," for the opposing attorney to say, "Well, how many times have you had occasion to estimate percentage of disability?" And if the doctor says "Never," I don't think the referee or deputy would pay very much attention to his appraisal. So in spite of my great admiration for the family doctor, I'd have to say in the Workmen's Compensation field the answer is "no."

DR. FEATHERSTON: Here is a question that might provoke some discussion:

"As doctors probably make no more nor less mistakes than twenty-five years ago, what has produced the tremendous increase in litigation in medico-legal cases? Who or what is priming the pump—the lawyers or the doctors?"

JUDGE PROCTOR: The doctors don't make the medical cases; the automobiles usually make the medical cases. The roads are crowded, the cities are crowded, the people are living closer together in the cities and when people are close together there is bound to be friction and bound to be accidents. And, of course, we know there are many, many times more automobiles on the road today than there were twenty-five years ago, and that's the reason for the litigation.

DR. FEATHERSTON: It has been suggested that whoever wrote that may mean malpractice cases.

JUDGE PROCTOR: I didn't know that there were any great influx of malpractice cases.

DR. FEATHERSTON: Mr. Horn, do you have an opinion on that?

MR. HORN: The same thing that produces them—the more people going to doctors today, the greater the number of mistakes made.

DR. FEATHERSTON: I have a rather definite

feeling that we are not being sued any longer for being negligent; we are just being sued for a bad result. The results of medicine now are so uniformly good that when something happens to a patient that isn't completely successful, it's got to be the doctor's fault. Now we face a fixed percentage against us. Every fracture isn't going to unite. Every fracture cannot be reduced. You *will* leave a stone in the common duct. You and everybody has done it who has done enough gall bladders. Is that the basis for a suit?

MR. HORN: Well, there is another factor here, actually, and that is the fact that people are now—I won't say insurance minded—but they know that there is insurance. Practically every physician is covered and they know it and they say: Well, we are not hurting our doctor. We'll let the insurance company pay for it. That has been the attitude that has also caused a lot of litigation in more recent years and that is probably one of the chief reasons, in my opinion.

DR. KAUFMAN: There has been a lot of misunderstanding about the nature of negligence. A great number of malpractice suits that are started in this part of the country are not really based on negligence but on poor results or on an opinion that there have been poor results. A great number of the negligence cases that are started are never followed and certainly even in some that are lost there is a question. The jury must decide whether there is negligence. What is considered medical negligence is not necessarily legal negligence.

DR. FEATHERSTON: Presume that you have been requested by an insurance company to examine and evaluate an individual seeking damages; later the attorney for the plaintiff demands a copy of the findings; what would be your procedure?

DR. KAUFMAN: The procedure in that case is to advise him to communicate with the attorney who has employed you to examine that particular person and the attorney is the one to give him the copy of your report.

DR. FEATHERSTON: That's correct, and in turn they have the privilege of exchanging reports. If you ask for a defense report, you have to supply the plaintiff's report.

DR. KAUFMAN: I think it is the duty of the attorneys to furnish those and not the physician.

DR. DAVIDSON: In this connection, there has been some question about access to hospital records. Where an insurance company wants the hospital record librarian to surrender the record to its representative, sometimes the private doctor, who would normally be the plaintiff's physician, doesn't want to do this. The attending physician might feel that, after all, this is a personal confidential record and why should it be surrendered to some one in an adversary proceeding? And then the suggestion has been made that you will first get the patient's consent. If there is something in that record which would hurt the case, the patient isn't likely to consent. And this has brought up — it's a very interesting ethical question, too—the problem of access to hospital records.

JUDGE PROCTOR: Many times they come in and get a court order to get those and they are always granted, or at least I don't recall any that was never granted.

DR. FEATHERSTON: I think the act is known as the Proctor Act.

JUDGE PROCTOR: It was years ago.

DR. FEATHERSTON: May a doctor as a witness be compelled to reveal facts of a confidential nature about the patient, without the patient's consent?

DR. KAUFMAN: In this state, differing from some of our sister states, there is no confidential relationship between patient and doctor, and a doctor may be required in court to testify as to anything that he knows about a patient.

JUDGE PROCTOR: Someone asks this question: "Because of drunken driving or driving under the influence of intoxicating liquor, and admitting that, in many cases they are found not guilty by the magistrate's court due to the poor presentation by the arresting officer and browbeating of the medical witness by the defendant's attorney, would not one of the answers to this problem be a prosecuting attorney for each court?"

Well, of course, that would be an answer to the question, but it would be most expensive for every municipality, particularly a small municipality, to have a prosecutor. Some of the larger cities do have prosecutors in municipal courts. That is a matter for each particular town, or the legislature. I don't think I could answer that.

MR. HORN: Don't you think, Judge Proctor, that although that used to be true, it is gradually becoming untrue in the drunken driving cases today, with the new kinds of gadgets such as drunkometers and all the other kinds of things they have?

JUDGE PROCTOR: Yes, I do. There may be some individual case, but there are certainly not many cases where people are getting away with things like they used to.

DR. FEATHERSTON: Dr. Davidson, how can the idea or concept of subjective pain be got-

ten over to a jury by the doctor who is a witness?

Dr. Davidson: Every member of the jury has at some time felt pain and so there wouldn't be any difficulty of conveying to a juror that there is such a phenomenon. I presume what the questioner means is how can the doctor convey to the jury the reality of the subjective symptom of pain and counteract the idea that the patient just pretends that he is feeling pain in order to collect money. I suppose that the person writing the question assumes that the patient *does* have pain and that he is bothered because the jury may be told by the defense attorney: "Well, he just says he's got a backache but how do we know he has a backache? He is trying to collect money."

The answer that I would always give in such a situation is that we do not diagnose pain simply by the patient's self-serving statement "I have backache." This is a very naive way of interpreting it. We say that the patient has pain because the general picture looks like it, because his posture looks like it, because of the various psychomotor tensions which he displays, because of the unconscious guarding of his body as he moves, and because of the picture which pain writes in a person's face. We, as doctors, are skilled in interpreting these nuances of face, posture and so forth. We do not just say this man has pain because he tells me he has pain. He has pain because I am skilled in recognizing it and from the total picture. I'm convinced that this man is suffering, and that's the way to do it.

Mr. Horn: May I tell you a story? I guess it goes back about ten years. There was a Workmen's Compensation case down here; it was a back injury, and this fellow came into the Compensation court on many occasions. He was all trussed up with a brace and he walked very slowly and sat with great care and everything else. And there were three doctors who testified in that case. Two of them said unquestionably this man's got a hundred per cent disability; he will never be able to work again; he can't bend; he can't do this, and all the tests were so and so. One of those three doctors said: "If this man's condition is as he describes it and if he says that he can't do this and if he says he can't do that, then I'd say that he is a hundred per cent disabled." Well, he turned out to be a very smart fellow because the defense put on moving pictures showing him lifting cases of milk when he wasn't looking. Remember that, Dr. Allman? Dr. Allman was the one who said: "If he says so and so."

Dr. Featherston: That's very good.

I'm sure that you have just heard what is the best way to get the fact over to the jury that a patient has pain, and that's to get a psychiatrist to tell the jury. (Laughter)

Dr. M. W. Bergman: I'd like to add to Dr. Davidson's statement: dilated pupils for pain and that the course of the nerve is compatible with organic neurology; that the nerves run in certain courses, and when you do sensory tests you can map out pain, and if you add that to the general attitude, the emotional reaction you are asked to assume in the hypothetical question, I think you can prove it.

Dr. Kaufman: You notice these psychiatrists have quite a jargon, too. (Laughter)

Dr. Bergman: I'd like to say that I don't belong to the group of psychiatrists who conceptualize the vagaries of the machinations of the mind. (Laughter)

Dr. Featherston: I think that just closes the meeting.

Ladies and Gentlemen, thank you very much for coming. (Applause)

(The General Session was concluded at 9:55 p.m.)

DINNER - DANCE

Tuesday Evening April 30, 1957

The speakers' section of the Dinner-Dance Program convened at 8:40 p.m. at Haddon Hall, Dr. C. Byron Blaisdell, Toastmaster.

THE TOASTMASTER: Mr. President, Mrs. Fritts, Members of the Woman's Auxiliary, Members of the Medical Society, Wives, Guests and Friends:

We want to express our thanks and appreciation to our hostesses of the evening, the members of the Woman's Auxiliary to The Medical Society of New Jersey, who are making this such a pleasant and memorable occasion.

It is a great pleasure, therefore, to introduce to you the President of the Woman's Auxiliary to The Medical Society, coming from Elizabeth in Union County — Mrs. Bertram J. L. Sauerbrunn. (Applause)

MRS. BERTRAM J. L. SAUERBRUNN: Thank you, Dr. Blaisdell.

In behalf of the doctors' wives of New Jersey, especially the one who is sitting by your side, I bid you welcome. Since that victorious day when we persuaded you to take unto yourselves a wife, we have fulfilled the duties of mother, nurse, technician, bill collector, private secretary, bartender, and chief cook and bottle-washer. (Laughter) In return, you have clothed, coiffed, consoled and caressed us so well that it is the aspiration of ninety-nine per cent of all unmarried females to join the exclusive circle of doctors' wives. (Applause)

The generosity of your Medical Society to our Auxiliary is a topic about which we boast wherever we go. That you are pleased to give us such liberal financial support to our assorted projects is a source of great satisfaction to us. The facilities of the Medical Society headquarters which you have made available to us contribute immeasurably to the efficient functioning of our organization. The experienced counsel of Mrs. Madden and Mr. Nevin help us considerably to administer to our affairs. Above all, the moral support you give us makes life worth living and the deed worth doing.

For obvious reasons, you have inspired our theme for this year—protect your handsome investment. By unanimous vote of the Executive Board, we have decided that our husbands are the handsomest in the land. (Applause) Although I will have to admit privately that that man on the end of the table, next to Mrs. Blaisdell, is the handsomest of them all. (Applause)

We have also decided by unanimous agreement that our investment in you is enormous. If we, therefore, appear to be a bit shrewish when your professional cares keep you overly occupied, please forgive us. It is our handsome investments that we are seeking to protect.

And so, without further ado, let me urge you for tonight to lay aside your stethoscopes and inevitable shop talk to do honor to our splendid President and his beautiful wife—Dr. and Mrs. Lewis Fritts. Thank you so much. (Applause)

THE TOASTMASTER: We certainly must admit that was quite a testimonial. That was high praise, indeed, and it is nice that some streets are two-way streets. I think we can promptly return the compliment and say no man has ever had better helpers nor any more beautiful. (Applause)

Judging from that hearty applause, I think it is evident that you are taking a full reward, Mrs. Sauerbrunn, of appreciation and affection back to Union County, where, I might say, that the royalties have been a little below par recently. (Laughter)

It occurs to me that you elected in Union County a woman, Mrs. Florence Dwyer, to Congress, which makes it quite apparent which sex wins most of Union's laurels this year. (Laughter)

Never mind, fellows. I mean for a while we may seem to be having a disappointing batting average this season. You certainly want to see us all up there slugging and swinging together next year with, shall we say, unabated enthusiasm for the whole team.

It is now my very pleasant pleasure to introduce three distinguished people. Their names are on your programs. These three are three to whom the future is flinging wide its brightest doors to lead to more success and achievements. They are listed in your programs, as I said, and they will be asked to rise and take a bow.

First I would call upon Mrs. John C. Voss, President-elect of the Woman's Auxiliary to The Medical Society of New Jersey, Mrs. Voss. (Applause)

Next, and sitting on her right, I would like to ask Dr. Albert B. Kump, President-elect of the Medical Society to rise. (Standing ovation)

Next, I will call upon the gentleman on my right to rise—Dr. David B. Allman, Presi-

dent-elect of the American Medical Association. Dr. Allman. (Standing ovation)

I'm quite certain that you will agree that they are an elect and distinguished group—all three of them "elect."

Now, it has been said that most men would rarely be successful and frequently would be under-developed if it were not for their wives. Mrs. Sauerbrunn certainly developed our side of it. I think we should develop the wives' side of it. You have, of course, in addition to your recognized natural advantages, beauty, grace and charm, to list only a few. You have also the advantages of customs which let you come here in these very beautiful gowns so one hardly knows which way to look to see one that looks better than the last. I'm particularly susceptible to white and blue. Also jewels and exotic flowers; also there are the rather subtle and perhaps seductive perfumes which you bring; and then onto that you can add the entire rainbow.

In this area, of course, we men cannot possibly aim to compete, and so therefore I would like now to ask the pleasure of introducing to you the distinguished wives sitting here at the table.

(The Toastmaster then introduced the guests at the head table.)

(The Toastmaster introduced the following Fellows: Drs. Sommer, Ely, Crowe, Murray, Decker and Lance.)

THE TOASTMASTER: Now, at this time the real significance of the evening becomes increasingly apparent. It has been a wonderful year and at this 191st meeting we are coming to the consummation of the year which is going. The significance of it is to do honor to one whom we all admire, have come to love, who has borne a heavy burden this year with the Society.

And so, therefore, without doing anything more I would like to ask Dr. Butler to come up and properly introduce the gentleman to whom I was referring. Dr. Butler, as immediate Past-President, will you come forward? (Applause)

DR. VINCENT P. BUTLER: Mr. Toastmaster, Dr. and Mrs. Fritts, Honored Guests, Ladies and Gentlemen:

Tonight the Woman's Auxiliary to The Medical Society of New Jersey is honoring Dr. and Mrs. Fritts upon the completion of Dr. Fritts' term as President of the Medical Society. I think it is fitting that this honor is being accorded to both Dr. and Mrs. Fritts, for as President of the Medical Society one receives a considerable degree of help from those in the executive office in Trenton, from the Board of Trustees, the various committees and the individual members: but of all the help that he receives I don't think any is quite equal to that which he receives from his wife. Her tolerance, forbearance, counsel and cooperation are invaluable assets to the conduct of his office. And I am sure that it is on this account, to a great degree, and the understanding that you women folks have of this that you include Mrs. Fritts with Dr. Fritts in this distinguished honor.

At this dinner another honor is accorded to the President, and Mrs. Fritts derives a great deal of satisfaction from it. That is the induction of Dr. Fritts as a Fellow of The Medical Society of New Jersey.

Each year the honor of being President falls to the one man who, in the opinion of his fellow members, possesses the highest qualities of leadership and integrity to be the symbol of organized medicine in New Jersey. This year that leader has been Dr. Fritts and I need not tell you with what honor and distinction he has conducted that office and brought to it great honor and distinction and it is on that account that we are all here to pay tribute to him this evening.

To be chosen as one of more than five thousand fellow doctors as the President of the oldest Medical Society in the country places one in a very select group, for only one man is chosen each year. Though many aspire to it only one acquires that honor.

Then having served as President he qualifies for entrance into another select group—the Fellows of The Medical Society of New Jersey. This is a small group by which a medical society seeks to express its gratitude to the man who has filled the office of President, and the mark by which he is distinguished is a gold fellowship key which binds him, as long as he lives, to The Medical Society of New Jersey and confers upon him privileges which only a Past-President and no other member possesses.

It is my privilege at this time to present this token of appreciation and permanent memento of membership to Dr. Fritts, and welcome him as a Fellow and hope that he wears this good fellowship key for many more years in good health.

Dr. Fritts, I present this to you.

(Standing ovation)

PRESIDENT FRITTS: I haven't prepared any speech. I'm going to try to say a few words to you from my heart. I don't need any paper for this; I don't need any notes.

During the past year there was some question as to whether I would serve in this office of President of The Medical Society of New Jersey, but I have been able to, and for that I thank the Lord. And I have a great deal of faith in the Lord.

I want to thank my wife. She has put up with a good bit this past year. And I want to thank my children also. They, too, have put up with a good bit.

This year has brought to me many things for which I am thankful. It has brought me a great many friends whom I didn't know before. It has brought me to know better the things that are worthwhile in this life.

I want to thank Mrs. Madden and her group for the wonderful help that they have given me in conducting this office.

I want to thank Mr. Nevin and his group publicly for the great help that he and they have offered and freely given.

I want to thank the members of the Board of Trustees, and I want to thank particularly Dr. Blaisdell, who has been most kind and helpful in this past year in advising and in being willing at all times to talk any problem over.

I want to thank Albert Kump for the same thing. And there are so many here that I want to thank personally, but I will just say to The Medical Society of New Jersey: Thank you all. (Applause)

The Toastmaster: As one of our friends remarked last night, all the gardens are not in Gethsemane.

However, to go on to the rebuttal, you said that the children might have had a hard time from you, but I think sometimes the children give us a bit of a time, too. I think that is a two-way street again, because I know speed records are being broken quite frequently on Route 22 and you have to keep your eyes open to see how things go over that highway. Ann, I don't mean anything by that.

(Laughter)

Last year Dr. Donnelly, who was up here and talking, saw fit to summarize a bit of his impressions of the Annual Meeting. I will not be so ambitious, but I can say that certain things have stood out this year and we have certain people with us who are certainly doing things in a big way.

I mentioned Dr. Lance, who has set the precedent of being the first Speaker and taking that honor back to Union County.

We have also over here in Dr. Allman a man who is the first challenger of Secretary Dulles for mileage. (Laughter) He is going to start out for Istanbul with his lovely wife very shortly.

The other day I was talking to him and I said, "How about coming up to a meeting in New York next November?" He opened his book and he said, "Oh, no, that's for 1958. You are talking about 1957." He is already dated up to 1958, and on the one night that I asked him for in November, he already had two engagements. He comes home every once in a while to take care of his three hundred goldfish. (Laughter)

Also, of course, we have had the pleasure of seeing men come up from the other counties. We have seen Dr. E. A. McCall, who is now going under the alias of Jesse McCall, come up from over Newton and finish a term as treasurer with apparently no scathing remarks from Dr. Allman and the Finance Committee. But he is going into a great brotherhood. But let me tell you, he comes from a great brotherhood, and If Jess survives Albert Kump and Carl Ware, I think that he will really have proved himself for the position he is going to hold. Some of that you may know a little bit about as time goes on.

We also have some remarks to make about Mrs. Edith Madden. Edith last year was sung "Happy Birthday To You" from the platform and by those of you who attended because her birthday falls on May 15. She was toasted in a double chocolate malted. Edith is here with us and I asked her how old she was this year, and she said, "Why, don't you know? I'm going to be thirty-nine." So that Edith is now celebrating her thirty-ninth birthday in anticipation by two weeks, but I would like to have you all just give her a bit of applause.

Edith, will you stand up and take a birthday bow? (Applause)

Dick Nevin is to be congratulated on doing a swell job for the Society and helping us sometimes get our wheels back on the tracks and making progress.

I think that perhaps the most significant thing of this year's meeting, though, as I see it, has really been the sense of unity, despite what may have been said in the House of Delegates at times, really extending from one state's end to the other. I think that increasingly we are beginning to recognize people year after year coming back, working hard really in behalf of the Society and carrying on the inspiration passed on to them by the Fellows whom we had the pleasure of saluting here tonight. We really constitute a great body.

One of the men from the A.M.A., who was over here visiting the Board of Trustees and

seeing the membership, said, "Really, you fellows in New Jersey have one of the swellest medical societies in the whole United States." And I think it really can be said that we are trying hard to do a good job to keep our feet on the ground and do what we can in medicine.

We are not going to have any speeches tonight. And I have been told so many stories to tell you that as I tried to appraise them and evaluate them, starting from the birds that fly a mile, up to people who can't count, and the number of other significant stories led by provocateurs, I decided not to try to be funny, but leave that to your own imagination and get those fellows tied down later on. There is a limit to what one can do in a short period of time, and I think that even Dr. Bacon, sitting out there, has received numerous testimonials from Dr. Kump in the past, and other groups, which perhaps—well, we'd really have fun if we could describe those things. Actually, you could really get "yancey" once in a while. (Laughter)

And so, to make this program short and not to try to do something for which I am not personally equipped, I think now the thing to do is to turn the program over to the entertainment part and the strictly musical and dancing and other sense, to Joe Stern over there, who always does a swell job. We must say that he and the hotel, thanks to the integration of the efforts of Mrs. Madden and company, certainly always contribute to entertainment.

So, Joe, will you take the microphone over now, and I'll leave it there. (Applause)

(The speakers' portion of the program was concluded at 9:10 p.m.)

The New York Academy of Medicine

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